DRAFT

CALIFORNIA MENTAL HEALTH MASTER PLAN

Prepared by

California Mental Health Planning Council

August 2001

TABLE OF CONTENTS

CHAPTER 1

MISSION AND PHILOSOPHY OF CALIFORNIA'S MENTAL HEALTH SYSTEM

WHAT ARE THE VISION, MISSION, AND VALUES OF THE PUBLIC MENTAL HEALTH SYSTEM?

The mental health constituency envisions a society in which persons of all ages, backgrounds, and cultures who experience serious mental illness or serious emotional disturbance receive high quality, effective services from the mental health system. As a result of the services, support, and rehabilitation they receive, these persons are able to lead happy, productive, fulfilling lives.

The mission of California's public mental health system is to enable adults and older adults with serious mental illnesses and their families and children and their families to access services from a seamless system of care. These services will assist them, in a manner tailored to each individual, to achieve their personal goals and optimal recovery and to develop skills that support living the most constructive and satisfying lives possible in the least restrictive environment. The mental health system shall help children achieve optimal development.

The following values should guide development and implementation of the public mental health system:

1. **Client-directed Approach.** All services designed for adults and older adults with serious mental illnesses and their families and for children and their families should be client-directed, and guided by an individual's goals, strengths needs, concerns, motivations, and disabilities.

   - Adults and older adults with serious mental illnesses:
     - have all rights, privileges, opportunities, and responsibilities as do other members of society;
     - are the central and deciding figures in all planning for treatment and rehabilitation based on their individual needs. Planning may also include family members and significant others as a source of information and support; and
     - should be fully informed, fully involved, and voluntarily agree to all treatment and rehabilitation provided. If an individual is legally found incapable of consenting to treatment, then he or she should be informed and involved to the greatest extent possible.
   - Children, youth, and their families:
     - should be involved in designing their treatment plans;
     - should have treatment plans based on the strengths and resources of the child and family; and
     - should have treatment plans that acknowledge the family as a resource and that empower the family system to operate effectively.
     - should be involved in state and county level policy setting, system planning, program design, and evaluation of all elements of the service system.

2. **Access to Services for Target Populations.** Adults and older adults with serious mental illnesses and children with serious emotional disturbances have severe, disabling conditions giving them a right to effective treatment and a high priority for receiving services.

3. **Focus on Recovery.** Mental health services should assist clients in their recovery to return to the most constructive and satisfying lifestyle of their own definition and choice. For some clients, spirituality may define well being and should be incorporated into the recovery process.

4. **Systems of Care.** Systems of care should consist of coordinated, integrated, and effective services meeting the unique needs of children and their families and adults and older adults with serious mental illnesses. These systems of care must operate in conjunction with an interagency network of other necessary services. Clients must have available an identifiable and qualified person or team responsible for their support and treatment. Systems of care should provide treatment and rehabilitation in the most appropriate and least restrictive environment, and if possible, in a community of the client's choosing.

5. **Outreach.** All adults and older adults with serious mental illnesses and their families and children and their families should have access to crisis intervention on a 24-hour basis. Assertive outreach should make mental health services available to homeless and isolated individuals with serious mental illnesses.
6. **Multiple Disabilities.** Mental health services must address the special needs of children and youth, adults, and older adults, including persons with co-occurring psychiatric disabilities and substance abuse and persons with multiple disabilities.
7. **Qualified Staff.** Qualified individuals trained in the client-directed approach must provide effective services based on clients' goals and deliver those services in environments conducive to helping clients achieve their goals.
8. **Involvement of Direct Consumers and Family Members in Delivering Mental Health Services.** The mental health system should maximize participation of direct consumers and family members as both paid and volunteer staff.
9. **Cultural Competence.** The mental health system at all levels must have the capacity to provide services that are gender sensitive and culturally congruent with the clients' cultural and ethnic backgrounds, beliefs, and lifestyles.

    - Cultural competency is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations.
        - "Culture" implies an integrated pattern of human behavior, including language, thoughts, beliefs, communications, actions, customs, values, and other institutions, of racial, ethnic, religious, or social groups.
        - "Competence" implies having the capacity to function effectively within the context of culturally integrated patterns of human behavior as defined by each cultural group (Cross, 1989).
    - The cultural identities and worldviews of the consumers shape health and healing beliefs, practices, behaviors, and expectations. Wellness is uniquely defined by each individual and each cultural group.
    - A culturally competent system of care acknowledges and incorporates the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs (Cross, 1989).
    - A culturally competent system of care promotes for itself and among its providers the following characteristics:
        - awareness of the value of diversity and developing adaptation to diversity;
        - the capacity for continuous self-assessment;
        - institutionalized cultural knowledge;
        - awareness of the dynamics inherent when cultures interact; and
        - congruent behaviors, attitudes, and policies enabling the system, agencies, and mental health professionals to function effectively in cross-cultural institutions and communities (Cross, 1989).
10. **Peer Support Models.** The mental health system must promote the development and use of self-help and peer education and training for adults and older adults with serious mental illnesses and of peer support for adults, older adults, children, youth, and families. Self-help and peer support must be available in all areas of the State.
11. **System Accountability.** State and local mental health systems of care must be accountable for the quality of their mental health services. This accountability is provided when state and local mental health programs use performance indicators to evaluate the effectiveness of their mental health services and to improve their quality.

12. **Administration.** State and local departments of mental health must manage programs in an efficient, timely, and cost-effective manner consistent with the values and principles of the *California Mental Health Master Plan*.

13. **Research.** The mental health system must encourage basic research into the nature and causes of mental illnesses along with effective prevention, intervention, and rehabilitation strategies. The mental health system should actively cooperate with research centers in efforts leading to improved treatment methods, service delivery, and quality of life for mental health clients of all ages. Mental health professional organizations should be encouraged to disseminate the most recent research findings on prevention, early intervention, and treatment of mental illness and serious emotional disturbances. Mental health research and evaluation should also be focused on issues critical to women and sensitive to issues of ethnicity, age, and sexual orientation.

14. **Education about Mental Illness and Serious Emotional Disturbances.** Family members, care givers, and consumers should receive education and training based on numerous models that have been developed by state and national organizations.

15. **Anti-Stigma Campaigns.** The mental health community must work to eliminate the stigma associated with having mental illness or a serious emotional disturbance. Consumer and family advocates for mental health must be encouraged and assisted to inform the public about the nature of mental illness and serious emotional disturbances from their viewpoint and about the needs of consumers and families.

16. **Advocacy Services.** To assure the rights of persons with mental illnesses and of children and their families, the mental health system must be an advocate for patients' rights. The mental health system must also assure that consumers, and families of adults, older adults, and children are involved in providing advocacy at all levels.

17. **Respect and Dignity.** The social interaction between providers and clients should conform to the highest available standard of respect and dignity. A process for dialogue between the clients and the providers should be initiated. This process should address the moral role imbalance attendant upon the dominant social position of the providers and compensate for it.

18. **Partnership.** The State Department of Mental Health, the Planning Council, the mental health boards and commissions, and other mental health organizations should strive to create a partnership of cooperation and a shared vision for the mental health system.

CHAPTER 2

COMMITMENT TO CULTURAL COMPETENCY

BACKGROUND

Cultural competence has been described generally as the ability to appreciate and recognize culturally different people and to be able to work effectively with them (Sue, 1998). As Sue, Zane, & Young (1994) explain, a client's culture is relevant to the provision of mental health services because it affects the assessment, etiology, and symptom expression of mental illness, and it affects the client's treatment preferences. Cross (1989) has defined cultural competence as a congruent set of attitudes, behaviors, and policies that enable a system, agency, or provider to treat culturally diverse clients effectively.

The Little Hoover Commission (November, 2000) reported that, as California's population has grown in size and diversity, the mental health system has strained to keep up with the need for care. Cultural and language barriers to mental health care are particularly significant. The barriers to care are as simple and as intractable as not being able to communicate because no county staff who speak a client's language are available when necessary.

More research is necessary to determine how to provide appropriate mental health care to a racially, ethnically, and culturally diverse population. The Report of the Surgeon General (1999) states that, "...to be culturally competent is to deliver treatment that is equally effective to all sociocultural groups. The treatments provided must not only be efficacious (based on clinical research), but also effective in community delivery," (p.91). The report continues by pointing out that most research on efficacy has been conducted on predominantly white, English-speaking populations, making delivery of effective treatment to culturally diverse populations complicated because little or no empirical data exists with regard to these populations.

To further emphasize this point, an epidemiological study was recently conducted in Fresno, California by Aguilar-Gaxiola and Vega (get cite from gaxiola when ready to finalize because this is being published) This study provides evidence that dramatic disparities exist in mental health care for Mexican-Americans that are not explained by prevalence rates. In Chapter 3, "Unmet Need for Public Mental Health Services," the issue of health disparities is further addressed by recommending that DMH conduct a study to determine unmet need among the major racial, ethnic, and cultural populations in California.

SYSTEM LEVEL DESIGN ISSUES

Governor and Legislature

Every component of the public mental health system needs to address cultural competency, including the State, the counties, and individual providers. At the state level, the Legislature should play an active role in establishing cultural competence by enacting laws that require state agencies and counties to implement culturally competent practices and that provide funding to do so.

Recommendation: The Governor and the Legislature should provide sufficient funding for counties to recruit, hire, and retain bicultural and bilingual staff.

Recommendation: The Governor and the Legislature should allocate resources to secondary and postsecondary institutions to train bicultural and bilingual staff.

Recommendation: The Governor and the Legislature should provide funds for loan forgiveness programs to recruit bilingual and bicultural students into training programs.

Recommendation: The Governor and the Legislature should provide funds to mental health providers to provide ongoing cultural competence training to existing staff.

State Department of Mental Health

The State Department of Mental Health (DMH) also plays a significant role in creating a culturally competent mental health system. It has convened a Cultural Competence Advisory Committee, chaired by a member of DMH executive staff and comprised of experts on cultural competence throughout California. This committee was instrumental in developing the cultural competence plans that DMH requires counties to prepare. (More discussion on these plans is included in Chapter 7, Managed Care.) As part of the onsite reviews of the county mental health managed care plans (MHPs), the DMH monitors counties to determine if the goals set forth in the

cultural competence plans are being actively addressed. The DMH also collects data on many performance indicators related to service utilization and outcome. By analyzing these data by race, ethnicity, and culture, DMH can identify any counties in which these groups are not faring well. Those counties with poor performance can be provided with technical assistance to increase the cultural competence of their service systems.

Recommendation: The DMH should aggressively monitor the county mental health plans (MHPs) for compliance with the goals established in their cultural competence plans. Any corrective actions plans should be given top priority by both DMH and the mental health plans.

Professional and Licensing Boards

Professional licensing boards also have a role to play. Many currently practicing professionals were trained in an era when the importance of cultural competence was not so widely understood. In order to accommodate the mental health needs of California's steadily growing diverse populations, this issue should be given a high priority.

Recommendation: Licensing boards should include training in culturally responsive treatment in their continuing education requirements.

County Mental Health Departments

Counties are also an important part of creating a culturally competent system. Each county in California is unique in its racial, cultural and ethnic diversity and is responsible for developing a system of care that meets the needs of its community. Counties provide mental health services directly through county-operated programs or by contracting with community agencies. Counties can enhance the cultural competence of their service systems in a variety of ways. One way is to provide "ecologically valid services" (Aponte & Wohl, 2000). Ecologically valid services enhance access by being provided in churches, housing projects, and other community facilities used by racial, ethnic, and cultural communities. Counties can also develop multiservice centers offering an array of social services, such as legal aid, housing assistance, income assistance, public health programs, and mental health services (Sue, 1977). This approach also makes it easier for members of racial, ethnic, and cultural communities to avail themselves of services. In addition, counties must facilitate interagency collaboration among social services, health, and mental health agencies to more effectively serve racial, ethnic, and cultural populations (Aponte & Wohl, 2000).

Recommendation: The county mental health departments should develop effective outreach strategies to locate services where clients of various racial, ethnic, and cultural groups will be most likely to access them.

Recommendation: The county mental health departments should actively facilitate the interagency collaboration among social services, health, and mental health agencies to more effectively serve racial, ethnic, and cultural populations.

Mainstream Mental Health Agencies

Agencies that provide mental health services to clients of all races, ethnicities, and cultures, are called "mainstream agencies." These agencies need to be able to serve clients of all cultures competently. First, they need to hire bicultural and bilingual staff of the racial, ethnic, and cultural groups in their service area (Sue, 1977). Hiring paraprofessionals from the racial, ethnic, and cultural groups being served is another way of meeting this need (Aponte & Wohl, 2000). These agencies also need to offer continuing education to their staff about issues related to serving diverse populations and culturally responsive treatment techniques (Sue et al., 1994). In addition, especially for clients who are not very acculturated, providing an orientation prior to providing services can be particularly useful to help these clients understand the treatment process, what is expected of them, and what the therapist can provide to help them (Sue et al., 1994). Finally, agencies should structure their services so that they take advantage of natural helping networks and support systems in the community, which can make mental health services more accessible to racial, ethnic, and cultural groups (Aponte & Wohl, 2000).

Recommendation: The DMH should require the county mental health departments and the agencies with which they contract to establish goals for hiring bicultural and bilingual staff, including paraprofessionals, and provide continuing education on cultural diversity to existing staff.

Recommendation: The DMH should encourage county mental health departments and the agencies with which they contract to provide an orientation prior to providing services to racial, ethnic, and cultural populations, including structuring services so clients can use natural support systems in their own racial, ethnic, and cultural communities.

MULTICULTURAL COUNSELING CONCEPTS AND COMPETENCIES

Providers need to have two sets of skills: multicultural counseling competencies so that they are able to serve all racial, ethnic, and cultural groups and a specific understanding of the unique needs and preferences of each racial, ethnic, and cultural group. In the Appendix at the end of this chapter, D. Sue, Arredondo, & McDavis (1992) describe multicultural counseling competencies by categorizing them into three areas that a therapist needs to incorporate into his or her beliefs, knowledge, and skills:

- Awareness of one's self, including values and biases
- Understanding the worldview of culturally diverse clients
- Developing culturally appropriate treatments

The beliefs, knowledge, and skills related to developing an awareness of one's own self mostly relate to understanding one's biases, prejudices, and racism; trying to understand their effects on one's treatment approaches; and trying to overcome those biases. Developing an understanding of culturally diverse clients focuses on acquiring knowledge relevant to the racial, ethnic, and cultural groups that a therapist serves. Developing culturally responsive treatment approaches provides a number of examples of steps that a therapist can take. For example, in the area of beliefs, therapists should respect a client's religion, spirituality, and indigenous healing practices. Therapists should acquire knowledge of how generic counseling techniques can clash with a client's cultural preferences and should also understand the role that a client's family and community play in the client's life. In the area of skills, a therapist should be able to interact with the client in his or her preferred language. The therapist should also be able to engage in a wide repertoire of verbal and nonverbal helping strategies.

The American Psychological Association has adopted guidelines for working with ethnic, linguistic, and culturally diverse populations (Sodowsky, Kuo-Jackson, Loya, 1997). ***Although these guidelines are directed to psychologists, they can be used by all mental health providers, including clinicians, paraprofessionals, peer counselors, and advocates, including clients and family members:***

Knowledge about diversity. Psychologists are cognizant of relevant research and practice issues as related to the population being served. This includes the acknowledgement that ethnicity and culture affect the behavior of clients; considerations of the validity of the use and interpretation of test instruments; recognition of the limits of the psychologist's competencies and expertise; and seeking educational and training experiences to enhance understanding of minority clients.

Psychological client-counselor process. Psychologists recognize ethnicity and culture as significant parameter in understanding psychological processes. This requires an awareness of how both their own and their client's cultural background, experiences, attitudes, values, and biases influence psychological process and therapeutic interventions.

Client's collective culture. Psychologists respect the roles of family members and community structures, hierarchies, values, and belief systems within the client's culture.

Client's religion and beliefs. Psychologists respect clients' religious and/or spiritual beliefs and values, including attributions and taboos, because they affect worldview, psychosocial functioning, and expressions of distress. This may involve familiarity with indigenous beliefs and practices as well as the incorporation of religious/spiritual leaders and practitioners relevant to the client's cultural and belief systems into psychological interventions.

Client's language. Psychologists interact in the language requested by the client, and if this is not feasible, make an appropriate referral. Clients may be offered a translator who has a nondual relationship with the client and who possesses cultural knowledge with an appropriate professional background. Relevant test data are also interpreted in terms understandable by the client.

Client's experience of racism. Psychologists consider the impact of adverse social, environmental, and political factors in assessing problems and designing interventions. In doing so, types of intervention strategies to be used are matched with the client's level of need.

Psychologist's advocacy role. Psychologists attend to as well as work to eliminate biases, prejudices, and discriminatory practices. Thus, they are cognizant of relevant discriminatory practices at the social and community level.

Psychologist's client notes address cultural factors. Psychologists should document culturally relevant factors in client records. These may include, but are not limited to, factors associated with client's acculturation, extent of family support, level of education, and intimate relationships with people of different backgrounds.

Client's economic and political conditions. Psychologists know that culture, ethnicity, race, and socioeconomic and political factors have a significant impact on the psychosocial, political, and economic development of ethnic and culturally diverse groups.

Client's cultural identity. Psychologists facilitate clients' understanding, resolution, and maintenance of their own sociocultural identifications.

Client variables' interactions. Psychologists understand the interaction of culture, gender, and social orientation on client behaviors and needs.

ACCULTURATION AND RACIAL, ETHNIC, AND CULTURAL IDENTITY

Knowing a client's mode of acculturation and racial, ethnic, and cultural identity are important variables in providing services. Acculturation refers to the process that leads to changes in a person's values, attitudes, and behaviors as a result of interaction with a second culture (Aponte & Johnson, 2000). Berry and Kim (1988) identify four modes of acculturation that describe different ways that contact with the dominant culture can affect someone. Each mode is associated with different levels of acculturative stress, social competence and support, and overall psychological adjustment (Berry, 1998).

Assimilation. This mode is a shift toward the dominant culture coupled with rejection of the culture of origin. The person's goal is complete acceptance by the majority culture. These individuals run the risk of being rejected by both their families and communities and the majority culture. They may be prone to high levels of stress and anxiety, low self-esteem, and susceptibility to social problems (Aponte & Johnson, 2000).

Separation. Individuals in this mode retain their cultural identity, values, and behaviors while rejecting those of the majority culture. These individuals will be effective in their culture of origin but may not be able to negotiate successfully in American society. Individuals operating in this mode are more likely to turn to indigenous social supports and systems of care (Aponte & Johnson, 2000).

Marginalization. This mode occurs when an individual simultaneously rejects both ethnic and majority group cultures. These individuals are not socially effective in either culture, and they lack a sense of cultural identity. They are most likely to experience high levels of acculturative stress and psychological maladjustment (Aponte & Johnson, 2000).

Integration. This mode is also referred to as biculturalism. It involves adopting some majority culture attitudes and practices coupled with retaining ethnic group cultural practices and identity. These individuals demonstrate psychological flexibility and have a wide behavioral repertoire that enables them to be effective across varying cultural contexts.

Acculturation focuses on the values, beliefs, and behaviors of a person. Ethnic or racial identity relates to the process and outcome of integrating ethnic/racial aspects into a person's overall self-concept and identity (Helms, 1990). Identity development is a psychological process in which individuals become aware of or ascribe meaning to racial or cultural material and integrate this information into their overall self-concept (Aponte & Johnson, 2000). Ethnic identity describes an individual's awareness and sense of self as a racial, ethnic, or cultural being.

Acculturation and racial, ethnic, and cultural identity are associated with varying degrees of psychological health and adjustment and influence a person's help-seeking and treatment outcomes. Although related,

acculturation and ethnic identity are actually separate processes. For example, a person could have weak ethnic identity and high acculturation or weak ethnic identity and low acculturation.

CONCLUSION

California's commitment to cultural competence should encompass all aspects of the mental health system. This chapter is intended as an overview regarding cultural competence in California. It describes how a culturally competent mental health system should be designed and implemented. It includes methods for system design; multicultural competencies and counseling concepts; and acculturation and racial, ethnic, and cultural identity. In addition, other chapters in the Master Plan contain specific issues and recommendations regarding cultural competence within each system of care.

APPENDIX

	Counselor Awareness of Own Assumption, Values, and Bias	Understanding the Worldview of the Culturally Different Client	Developing Appropriate Counselor Interventions, Strategies, Techniques
Beliefs	1. Culturally self-aware 2. Aware of biases' influence 3. Realize personal limitations 4. Comfortable with client's racial, ethnic, cultural, and belief differences	1. Contrast own belief with client's in nonjudgmental fashion 2. Aware of stereotypes and preconceived notions about the different ways of racial and ethnic minority groups	1. Respect client's religious or spiritual beliefs/values 2. Respect indigenous helping practices and networks 3. Value bilingualism
Knowledge	1. How counselor heritage affects definition of normality and abnormality 2. How oppression, racism, discrimination, and stereotypes affect counselor work, allowing counselor to acknowledge individual racism 3. How counselor's social impact and communication style differences affect clients and how to anticipate their impact	1. Have information of particular group one is working with (e.g., life experiences, cultural heritage, and historical background of culturally different client) 2. Culture's effect on personality, choices and preferences for counseling approaches 3. Sociopolitical influences that impinge on minority life (e.g. poverty, racism, powerlessness)	1. How generic counseling skills may clash with cultural systems 2. How institutional barriers hinder minority usage of mental health services 3. Potential bias in assessment instruments 4. Minority family structure, hierarchies, values, and beliefs 5. Discriminatory practices in society
Skills	1. Seek out educational, consultative, and training experience to enrich understanding of culturally different populations, recognizing the limitation of your competencies 2. Understand self as a racial and cultural being and actively seek a nonracist identity	1. Understand relevant research and latest findings on cross-cultural mental health issues, disorders, and services 2. Become actively involved with minorities outside the counseling setting so one's perspective is more than an academic or helping exercise	1. Able to engage in a variety of verbal and nonverbal helping responses 2. Able to exercise institutional intervention skills on behalf of client 3. Consult with traditional healers or religious leaders 4. Interact in client's language 5. Aware of cultural limitations in assessment and testing instruments 6. Seek to eliminate biases, prejudice, and discriminatory practices 7. Educate clients in goals, expectations, rights, and counselor orientation

D. Sue, Arredondo, & McDavis (1992)

Rev. 8/6/01

CHAPTER 3

UNMET NEED FOR PUBLIC MENTAL HEALTH SERVICES

HOW MANY PEOPLE NEED PUBLIC MENTAL HEALTH SERVICES BUT ARE NOT RECEIVING THEM?

To develop long-range plans for improving the mental health system, policymakers and advocates need an estimate of the number of persons in need of mental health services from the public sector but who are not presently accessing those services. A number of methodologies exist for estimating how many people need public mental health services. The California Mental Health Planning Council (CMHPC) has reviewed several of these methodologies and applied them to California's population. Estimates using various assumptions are provided in the chapter. For statewide planning purposes, however, we believe that a reasonable estimate of unmet need for public mental health services is approximately 600,000 persons. To put this figure in perspective, approximately 460,000 persons were served by the public mental health system in fiscal year 1997-98. Thus, the public mental health system would need to more than double to meet the needs of all children and youth with serious emotional disturbances and adults and older adults with serious mental illness.

Table 1 presents a summary of all the estimates in the chapter. These estimates vary 436,435 to 2,027,157. Providing estimates of unmet need for mental health services assists county mental health programs and local mental health boards by giving them quantitative data necessary for advocating for increased state and federal funding for mental health services. Additionally, due to a variety of factors, including human resource shortages, geographic location, population growth rates, and socioeconomic status, some counties have more difficulty providing services to their persons in need. These estimates also show which counties and regions are experiencing the most difficulty providing services to persons in need.

Table 1: Summary of Unmet Need Estimates by Age Group

Age Group	Lower Limit CMHS (1)	Lower Limit CMHS (2)	Lower Limit Meinhardt (1,3)	Lower Limit Meinhardt (2,3)
0-17	123,592	271,978	123,592	271,978
18-20	28,888	28,888	33,339	33,339
21-59	191,913	191,913	239,963	239,963
60+	92,042	92,042	104,164	104,164
Total	436,435	584,821	501,058	649,444

Age Group	Upper Limit CMHS (1)	Upper Limit CMHS (2)	Upper Limit Meinhardt (1,3)	Upper Limit Meinhardt (2,3)
0-17	493,593	864,000	493,593	864,000
18-20	76,889	76,889	87,925	87,925
21-59	699,403	699,403	820,316	820,316
60+	225,145	225,145	254,916	254,916
Total	1,495,030	1,865,437	1,656,750	2,027,157

(1) Unmet need for 0-17 year olds is calculated based on children with SED and extreme functional impairment.

(2) Unmet need for 0-17 year olds is calculated based on children with SED and substantial functional impairment.

(3) Meinhardt's estimates do not apply to 0-17 year olds. In order to estimate total unmet need for all age groups using Meinhardt's prevalence rates for transition-age youth, adults, and older adults, CMHS figures have been used for this age group.

HOW WERE THE ESTIMATES DEVELOPED?

The CMHPC worked with the California Department of Mental Health (DMH) and the California Mental Health Directors Association (CMHDA) for more than a year to develop these estimates. The methodology draws on sound existing research and adapts the findings of that research to current conditions in both rural and urban regions of California. The initial draft was reviewed by the CMHDA Governing Board. Subsequently, county mental health directors were asked to comment on the estimates for their counties. The CMHPC's Policy and System Development Committee reviewed the comments and decided how to incorporate them into the methodology. The Children and Youth Committee reviewed the methodology for estimating unmet need among children with serious emotional disturbances (SED).

HOW CAN UTILIZATION OF PRIVATE SECTOR MENTAL HEALTH SERVICES BE ESTIMATED?

Some clients access mental health services through the private sector. Because the CMHPC does not want to overstate unmet need for public services, a method for estimating private sector utilization had to be developed. Several studies offer estimates of the proportions of people with serious mental illnesses (SMI) who access services through the private sector. For example, Meinhardt, et al. (1992) found that, of children and youth treated for SED over a 12-month period, 63.8 percent primarily used private services. The rest, 36.2 percent, relied on the public system. According to the same study, 57.9 percent of persons treated for SMI over a 12-month period used private services. The public system served the remaining 42.1 percent. Meinhardt et al.'s estimates were made in 1992, however, and many changes have occurred in the mental health system since that time. Some professionals in the field believe that the proportion of persons accessing the public system is now much greater than these estimates. For example, in a national study of mental health care use, Pacula and Sturm (2000) found that 65 percent of all persons with SMI living in the community accessed services through the

public system; however, the sample size for California was too small to generalize the results to the state level (Pacula, 2000).

Private sector access will also be affected by enactment of parity legislation. Many states have recently passed mental health "parity" mandates that require insurance coverage for mental illnesses to equal that for physical ailments. In California, Chapter 534, Statutes of 2000 (AB 88, Thomson) requires health care service plan contracts to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age and of serious emotional disturbances of a child under the same terms and conditions applied to other medical conditions. These benefits include outpatient services, inpatient hospital services, partial hospital services, and prescription drugs. The maximum lifetime benefits, co-payments, and deductibles applied to serious mental illness must be the same as those applied to other illnesses.

In a nationwide study, Pacula and Sturm (2000) found that "those states that are able to pass parity legislation do not experience significant increases in the utilization of mental health services. This may be due in part to a loss of coverage for those people most at risk for mental health disorders." In California, however, most people who have private insurance are part of a group plan, and are unlikely to be dropped as a result of the new legislation. Indeed, two of the state's largest providers, Kaiser and PacifiCare, are already in the process of hiring new mental health professionals to accommodate the anticipated increase in demand for their behavioral health care services.

Understanding access to the private sector is a crucial issue for mental health planning. Considerable uncertainty about how to estimate private sector utilization exists due to changes in the mental health system since Meinhardt et al.'s study was done in 1992; California's increasing growing diversity; and how the enactment of the parity legislation will affect access to the private system.

The issue of disparities in mental health care is gaining national attention. More studies are documenting disparities in quality, availability, and service utilization rates of mental health care for racial, cultural, and ethnic populations. Chapter 2, Commitment to Cultural Competence, discusses this problem. The methodology used in this chapter to estimate unmet need did not employ prevalence rates specific to each ethnic group. In addition, the Meinhardt et al. study about access to private sector services did not report access rates by ethnicity. Consequently, the findings of unmet need do not reflect disparities in access to mental health services for racial, cultural, and ethnic populations.

Recommendation: The State Department of Mental Health should commission a new study to determine the proportion of adults with SMI and children with SED in each major ethnic group who are able to access services in the private sector.

WHAT IS THE CMHPC'S METHODOLOGY FOR DETERMINING UNMET NEED?

Children and Youth

Estimated Prevalence of Serious Emotional Disturbance

To determine unmet need, the number of children and youth with SED had to be estimated. This process was difficult for a variety of reasons. No reliable prevalence data exist for children under the age of nine (Friedman, 1996, page 84). For children between the ages of 9 and 17, prevalence estimates vary. Variability in the prevalence estimates can be attributed, in part, to differing definitions of SED. Often, the question is not only "Who has a diagnosable disorder?" but also "Who are we required to serve?" Federal and state legislation differs in this respect. For example, California Code Title 22 §51340 Early Prevention, Screening, Diagnosis, and Treatment (EPSDT) requires county mental health programs to treat all children under age 21 who have a mental illness that can be corrected or ameliorated with treatment, whose treatment requires specialty mental health services, and who qualify for full-scope Medi-Cal benefits.

The California Welfare and Institutions Code (WIC) §5600.3 (a) defines target populations that should be given first priority for receiving services. WIC §5600.3 (a) (2) defines the children's target population as follows:

> For the purposes of this part, "seriously emotionally disturbed children or adolescents" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, other than a primary substance use disorder or developmental disorder, which results in behavior

inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

(A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

(i) The child is at risk of removal from home or has already been removed from the home.

(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide, or risk of violence due to a mental disorder.

(C) The child meets special education requirements according to Chapter 26.5 (commencing with §7570) of Division 7 of Title 1 of the Government Code.

The CMHS allocates federal funds to States through block grants for provision of community mental health services. The CMHS is required by law to establish a definition of SED and a method for making estimates of the overall prevalence in the population, and States then use these estimates as part of their application for funds under the block grant program. The CMHS (1996) defines SED as follows:

> Children from birth to age 18 who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the *Diagnostic and Statistical Manual (DSM)-III-R* and that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities. These disorders include any mental disorder (including those of a biological etiology) listed in *DSM-III-R* or their *International Classification of Disease (ICD)-9-CM* equivalent (and subsequent revisions) with the exception of *DSM-III-R* 'V' codes, substance abuse, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious emotional disturbance (Friedman, 1996, page 72).

Functional impairment is defined as follows:

> Difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included, unless they are temporary and expected responses to stressful events in their environment. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition (Friedman, 1996, page 72).

A CMHS work group reviewed a number of studies estimating the prevalence of children exhibiting various levels of functional impairment. The Children's Global Assessment Scale (CGAS) was the most commonly used instrument in these studies. The CGAS rates children's level of functioning on a scale from 0 to 100 with narrative descriptions of functioning at various levels. Lower scores indicate greater impairment. The work group decided to establish two levels of functional impairment based on the CGAS. Both levels meet the CMHS definition of "seriously emotionally disturbed."

The work group estimated that 5 to 9 percent of all children between the ages of 9 and 17 have a serious emotional disturbance and a level of functioning equal to or below a score of 50 on the CGAS. These children are said to exhibit "extreme functional impairment." The narrative description for a score of 50 or lower is as follows:

> Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area, such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, frequent episodes of aggressive or other anti-social behavior with some preservation of meaningful social relationships (Friedman, 1996, page 74).

DRAFT

The group found that 9 to 13 percent of all children between the ages of 9 and 17 have a serious emotional disturbance and a level of functioning equal to or below a score of 60 on the CGAS. The narrative description for a score of 60 is as follows:

> Variable functioning with sporadic difficulties or symptoms in several but not all social areas. Disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in settings where functioning is appropriate (Friedman, 1996, page 74).

Using this more inclusive criteria for functional impairment, 9 to 13 percent of all children are categorized as having a serious emotional disturbance accompanied by "substantial functional impairment." The CMHS definition of SED includes children with difficulties that substantially interfere with a child's functioning. Children with extreme impairment are subsumed in the substantial functional impairment definition of SED. The CMHS recommends that, from the standpoint of planning service needs, the 9-13 percent range should be used; however, according to the CMHS work group, "the…more conservative estimate can be used for more targeted efforts to plan on behalf of a more limited number of children whose level of functional impairment is especially severe" (Friedman, 1996, page 73).

The CMHPC decided to estimate the number of children suffering from SED based on the CMHS prevalence rates for children with extreme functional impairment and for children with substantial functional impairment. Initially, the CMHPC only calculated unmet need using the more conservative prevalence estimates. Using the conservative range still produced very high estimates of unmet need; between 127,936 and 498,370 youth with extreme functional impairment are not receiving any services at all. Some CMHPC members felt that presenting the conservative figures would be more effective and would allow for extrapolation. The alternative is to offer the more inclusive figures and run the risk that they will be considered inflated. However, some members pointed out that under EPSDT legislation counties are mandated to serve all children who meet the criteria for "medical necessity" in addition to those in the DMH target population. Children who have a substantial impairment according to the CMHS definition are likely to meet the EPSDT criteria for medical necessity.

In addition to being a function of definition, prevalence rates are also affected by socioeconomic status. The CMHS work group found that the prevalence rate is higher for children living in low socioeconomic circumstances and makes the following recommendations:

> States with a poverty rate more than five percent higher than the national average should use an estimate at the upper end of the prevalence range provided here (13 percent), and States with a poverty rate of more than 2.5 percent but less than 5 percent higher than the national average should use a prevalence estimate of 12 percent. Similarly, States with a poverty rate more than five percent below the national average should use a prevalence estimate at the lower end of the range (9 percent), and States with a poverty rate between 2.5 percent and 5 percent lower than the national average should use a prevalence estimate of 10 percent. States within 2.5 percent of the national average should use estimates in the middle of this range (11 percent) (Friedman, 1996, page 85).

The CMHPC heeded the recommendation of the CMHS to account for the impact of poverty on mental health. The methodology developed by the CMHS was applied to each county using both the 9 to 13 percent prevalence rate range and the more conservative range of 5 to 9 percent. Table 2 shows the prevalence rates used for each county. The lowest rate in each range (5 percent for the conservative range and 9 percent for the more inclusive range) was applied to 12 counties with poverty rates ranging from 5.2 percent to 8.4 percent. The 6 percent and 10 percent rates were applied to 8 counties with poverty rates between 8.5 percent and 10.7 percent. The 7 percent and 11 percent rates were applied to 24 counties with poverty rates ranging from 11.3 to 15.7 percent. The 8 percent and 12 percent rates were applied to eight counties with poverty rates ranging from 16.9 percent to 18.5 percent. The remaining six counties, with poverty rates ranging from 18.9 percent to 23.8 percent, were estimated to have a 9 percent or 13 percent prevalence rate. For example, in Imperial County, the poverty rate (23.8 percent) is 10.3 percentage points higher than the national average (13.5 percent), so a 9 percent prevalence rate (or 13 percent from the more inclusive view) is assumed. In contrast, Marin County has a poverty rate of 5.2 percent, so a 5 percent prevalence rate (9 percent using the more inclusive range) is assumed. The population figures of children age 0-17 in each county (See Table 3) were multiplied by the

corresponding prevalence rates to estimate the number of SED children with extreme functional impairment and with substantial functional impairment.

Number of Children and Youth Needing Public Mental Health Services

As already mentioned, some children with SED receive services from private providers. The CMHPC believes that the DMH must commission a study to determine the percentage of children with SED who rely on the public sector for services. Currently, Meinhardt et al.'s 1992 study provides the most accurate data applicable to California. In order to account for the changes to the system since that study, the CMHPC has provided a range for the number of children needing public services. To find the lower end of the range, the estimated number of children with SED was multiplied by 36.2 percent, the proportion of children expected to need public mental health services according to the Meinhardt study. The upper limit of the range is simply the estimated number of children with SED. This upper limit reflects the number of children who would need public services if no private services were available. For counties with populations under 200,000, a lower estimate was not calculated based on the assumption that a full range of private mental health services are not available in rural areas.

Unmet Need Calculation

The DMH provided the CMHPC with the number of clients served for fiscal year 1997-1998. In order to determine unmet need, the number of children served was subtracted from both the lower estimate and the upper estimate of children needing public mental health services. Table 2 shows the estimated number of children with extreme functional impairment who are not receiving services and the estimated number of children with substantial functional impairment who are not receiving services. The number of unduplicated clients reported by the DMH from the Client Data System excludes children with only one outpatient visit or only one inpatient visit less than four days. These exclusions were applied to the data so that the clients included in the utilization data were more likely to be long-term recipients of services as opposed to those needing only brief services.

Transition-Age Youth, Adults, and Older Adults

Estimated Prevalence of Serious Mental Illness

According to epidemiological studies, 6 percent of California's population suffers from schizophrenia, bipolar disorder, or major depression (Meinhardt, 1990). An estimated 13 percent have a diagnosis of dysthymia, panic disorder, phobia, obsessive compulsive disorder, or antisocial personality disorder (Meinhardt, 1990). However, as with children, the question is often not "Who has a diagnosable disorder?" but "Whom are we required to serve?" California's WIC §5600.3 (b) defines the target population to be served by the public mental health system as follows:

> For the purposes of this part, "serious mental disorder" means a mental disorder which is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Serious mental disorders include, but are not limited to, schizophrenia, as well as major affective disorders or other

Table 2: **Prevalence Rates and Unmet Need Estimate for Ages 0-17 by County**

DRAFT

COUNTY	SED with extreme functional impairment			SED with substantial functional impairment		
	Prevalence Rate	Lower Limit	Upper Limit	Prevalence Rate	Lower Limit	Upper Limit
Statewide		**123,592**	**493,953**		**271,978**	**864,000**
Alameda	6	5,002	18,926	10	10,269	33,475
Alpine	8	10	10	12	19	19
Amador	5	204	204	9	464	464
Butte	9	3,117	3,117	13	5,089	5,089
Calaveras	6	353	353	10	704	704
Colusa	7	296	296	11	520	520
Contra Costa	5	1,825	9,220	9	5,182	18,491
Del Norte	7	27	27	11	312	312
El Dorado	5	1,405	1,405	9	2,913	2,913
Fresno	9	5,902	20,547	13	9,596	30,749
Glenn	8	467	467	12	792	792
Humboldt	8	1,971	1,971	12	3,239	3,239
Imperial	9	3,295	3,295	13	5,152	5,152
Inyo	7	253	253	11	428	428
Kern	8	163	10,562	12	3,113	18,712
Kings	8	2,699	2,699	12	4,177	4,177
Lake	7	667	667	11	1,199	1,199
Lassen	7	285	285	11	570	570
Los Angeles	7	27,150	150,323	11	67,086	260,643
Madera	8	1,827	1,827	12	3,163	3,163
Marin	5	420	2,008	9	1,141	4,001
Mariposa	7	113	113	11	254	254
Mendocino	7	1,230	1,230	11	2,123	2,123
Merced	9	1,213	5,232	13	2,227	8,032
Modoc	7	68	68	11	166	166
Mono	6	151	151	10	258	258
Monterey	7	1,925	6,992	11	3,568	11,530
Napa	5	1,035	1,035	9	2,179	2,179
Nevada	5	741	741	9	1,534	1,534
Orange	6	8,657	37,298	10	19,491	67,227
Placer	5	637	2,458	9	1,464	4,743
Plumas	7	158	158	11	338	338
Riverside	7	4,400	23,444	11	10,575	40,500
Sacramento	7	3,729	18,169	11	8,411	31,103
San Benito	6	506	506	10	1,056	1,056
San Bernardino	7	6,565	30,116	11	14,201	51,209
San Diego	7	13,392	47,036	11	24,300	77,169
San Francisco	7	0	6,672	11	2,264	12,515
San Joaquin	7	1,904	9,275	11	4,294	15,877
San Luis Obispo	7	496	2,850	11	1,259	4,958
San Mateo	5	969	6,454	9	3,459	13,333
Santa Barbara	7	716	5,315	11	2,207	9,435

Table 2 (cont'd): Prevalence Rates and Unmet Need Estimate for Ages 0-17 by County

COUNTY	SED with extreme functional			SED with substantial functional		
	Prevalence Rate	Lower Limit	Upper Limit	Prevalence Rate	Lower Limit	Upper Limit
Santa Clara	5	3,071	16,853	9	9,327	34,135
Santa Cruz	6	417	2,828	10	1,329	5,347
Shasta	7	2,356	2,356	11	4,085	4,085
Sierra	6	24	24	10	53	53
Siskiyou	7	121	121	11	549	549
Solano	5	826	4,371	9	2,435	8,817
Sonoma	5	241	3,707	9	1,814	8,053
Stanislaus	7	1,133	7,060	11	3,055	12,369
Sutter-Yuba	8	2,640	2,640	12	4,341	4,341
Tehama	7	586	586	11	1,157	1,157
Trinity	8	187	187	12	312	312
Tulare	9	1,400	8,288	13	3,137	13,086
Tuolumne	6	304	304	10	739	739
Ventura	5	1,802	8,312	9	4,757	16,474
Yolo	8	2,541	2,541	12	4,132	4,132

> severely disabling mental disorders. This section shall not be construed to exclude persons with a serious mental disorder and a diagnosis of substance abuse, developmental disability, or other physical or mental disorder.

In 1990, the DMH funded Meinhardt, et al. to assess mental health needs throughout the State. The resulting study, *California Mental Health Needs Met by Local and State Hospital Services*, estimates county-specific prevalence rates of SMI. The rates are derived from the National Institute of Mental Health's Epidemiological Catchment Areas (ECA) Project. The ECA data were obtained through random household interviews in five sites in the United States. Interviews were conducted using the Diagnostic Interview Schedule (DIS), a highly structured interview that can be conducted by a trained non-professional. Interview results were analyzed to estimate the prevalence of disorders in the U.S. population as a whole. Since prevalence rates are affected by socio-demographic characteristics, Meinhardt determined the prevalence rate of each California county by adjusting the national prevalence figure to factor in each county's socio-demographic composition.

Meinhardt found that six percent of California's adult population suffers from schizophrenia, bipolar disorder, or major depression. The DMH estimates that one third of these, or two percent of the population, also has a major functional impairment related to the illness (California Department of Mental Health, 1999, page 116). This prevalence estimate is lower because the DMH does not include major depression as a diagnosis that would result in a major functional impairment.

In contrast, the federal CMHS estimates that 5.4 percent of adults suffer from a diagnosable mental disorder resulting in a serious role impairment (Center for Mental Health Services, 1999). The CMHS allocates federal funds to States through block grants for provision of community mental health services. The CMHS is required by law to establish a definition of SMI and a method for making estimates of the overall prevalence in the population. These estimates are then to be used by States as part of their application for funds under the block grant program.

The CMHS defines SMI as "the conjunction of a DSM mental disorder and a serious role impairment" (Center for Mental Health Services, 1999, page 33891). The following four criteria define SMI (Kessler, 1996, page 60-61):

1. A 12-month prevalence of schizophrenia, schizoaffective disorder, manic-depressive disorder, autism, and severe forms of major depression, panic disorder, and obsessive-compulsive disorder. Severe forms of major depression and panic disorder are indicated by either hospitalization or the use of major psychotropic medications. This criteria includes people who would have been symptomatic in the absence of treatment.
2. Any DSM disorder in the past 12 months accompanied by planned or attempted suicide within the past 12 months.
3. Any DSM disorder in the past 12 months accompanied by a vocational capacity substantially below expected level of functioning. One group of people in this category consists of people who are unemployed or working part time, living below the poverty level, and whose background and education are such that they would be expected to have at least twice their actual incomes. Another group in this category consists of people with a 12-month DSM diagnosis who consistently miss at least one full day of work per month as a direct result of problems with their mental health.
4. Any DSM diagnosis and complete isolation or only having relationships that are devoid of intimacy, the ability to confide, or the sense of being cared for or supported.

For the purpose of this chapter, prevalence of SMI was estimated using Meinhardt's county-specific prevalence rates and the standard rate published by the CMHS in the *Federal Register*. Some counties suggested using Kessler's 1997 report "Estimation of the 12-month Prevalence of Serious Mental Illness" (Kessler, 1997). However, Dr. Kessler's colleagues informed the CMHPC that they did not have much confidence in their county estimates because they lacked sufficient county-specific data.

The Meinhardt report (1990) provided county-specific rates for schizophrenia, bipolar disorder, and major depression. For each county, the combined county-specific rate for each of those illnesses (See Table 4) was multiplied by the population (See Table 3) for each adult age group, 18-21, 22-59, and 60 years and older. This calculation produced an estimate of the number of adults and older adults with SMI. The *Federal Register*

Table 3: County Populations by Age Group for 1998

COUNTY	Total	0-17	18-20	21-59	60-UP
Statewide	**32,956,588**	**9,251,040**	**1,686,917**	**17,377,723**	**4,640,908**
Alameda	1,398,590	363,725	64,009	777,807	193,049
Alpine	1,205	237	70	737	161
Amador	33,430	6,495	1,501	16,881	8,553
Butte	198,484	49,307	9,793	95,375	44,009
Calaveras	37,894	8,756	2,090	17,385	9,663
Colusa	18,524	5,601	1,177	8,686	3,060
Contra Costa	896,214	231,790	43,829	481,816	138,779
Del Norte	28,391	7,106	1,691	14,452	5,142
El Dorado	147,386	37,711	7,814	76,525	25,336
Fresno	778,656	255,049	45,163	374,934	103,510
Glenn	26,889	8,144	1,646	12,444	4,655
Humboldt	126,070	31,696	6,719	67,563	20,092
Imperial	142,674	46,414	10,502	67,092	18,666
Inyo	18,264	4,384	973	8,436	4,471
Kern	634,333	203,751	35,779	308,832	85,971
Kings	117,747	36,952	7,303	61,106	12,386
Lake	55,034	13,313	2,845	23,690	15,186
Lassen	33,787	7,125	2,423	19,482	4,757
Los Angeles	9,524,767	2,758,008	452,579	5,089,394	1,224,786
Madera	113,462	33,404	7,384	54,960	17,714
Marin	243,301	49,809	9,336	141,363	42,793
Mariposa	15,976	3,507	776	7,623	4,070
Mendocino	85,956	22,340	5,068	43,438	15,110
Merced	201,962	69,993	12,229	94,802	24,938
Modoc	10,152	2,442	637	4,782	2,291
Mono	10,582	2,655	424	6,215	1,288
Monterey	377,828	113,458	19,966	194,652	49,752
Napa	121,093	28,615	5,862	62,481	24,135
Nevada	88,368	19,826	4,688	42,294	21,560
Orange	2,705,287	748,205	122,544	1,485,433	349,105
Placer	215,505	57,107	11,562	111,836	35,000
Plumas	20,422	4,491	1,228	9,576	5,127
Riverside	1,423,664	426,409	72,303	682,793	242,159
Sacramento	1,146,882	323,332	57,035	600,443	166,072
San Benito	46,151	13,738	2,746	22,985	6,682
San Bernardino	1,617,385	527,327	90,355	813,837	185,866
San Diego	2,763,318	753,323	171,187	1,451,288	387,520
San Francisco	777,492	146,077	27,748	456,108	147,559
San Joaquin	542,193	165,046	30,061	268,276	78,810
San Luis Obispo	234,661	52,698	19,353	118,847	43,763
San Mateo	711,723	171,964	30,165	390,218	119,376
Santa Barbara	400,788	102,989	26,975	207,291	63,533
Santa Clara	1,671,410	432,041	75,312	948,118	215,939
Santa Cruz	247,252	62,984	13,412	136,092	34,764
Shasta	163,254	43,205	9,322	80,023	30,704

DRAFT

Table 3 (cont'd): County Populations by Age Group for 1998

COUNTY	Total	0-17	18-20	21-59	60-UP
Sierra	3,412	742	173	1,645	852
Siskiyou	44,199	10,698	2,718	21,117	9,666
Solano	378,676	111,139	20,434	202,424	44,679
Sonoma	432,751	108,651	20,759	231,587	71,754
Stanislaus	425,316	132,715	24,618	208,906	59,077
Sutter-Yuba	137,302	42,513	7,565	65,992	21,232
Tehama	54,623	14,293	3,260	24,931	12,139
Trinity	13,245	3,118	765	6,453	2,909
Tulare	358,359	119,952	22,684	166,893	48,830
Tuolumne	52,151	10,855	2,941	26,178	12,177
Ventura	727,250	204,051	38,224	385,318	99,657
Yolo	154,898	39,764	17,192	77,868	20,074

DRAFT

Table 4: Unmet Need Estimate Based on Meinhardt's County-Specific Prevalence Rates

COUNTY	Prevalence Rate Used	18-20		21-59		60+	
		Lower Limit	Upper Limit	Lower Limit	Upper Limit	Lower Limit	Upper Limit
Statewide		**33,339**	**87,925**	**239,963**	**820,316**	**104,164**	**254,916**
Alameda	6.53%	1,407	3,827	13,623	43,031	4,607	11,906
Alpine	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Amador	4.08%	46	46	424	424	321	321
Butte	6.06%	490	490	3,464	3,464	2,506	2,506
Calaveras	4.05%	68	68	432	432	363	363
Colusa	4.88%	51	51	274	274	131	131
Contra Costa	5.25%	673	2,003	5,517	20,135	2,565	6,775
Del Norte	5.28%	55	55	205	205	234	234
El Dorado	5.45%	378	378	3,344	3,344	1,319	1,319
Fresno	5.85%	540	2,070	1,665	14,365	1,819	5,325
Glenn	4.96%	60	60	249	249	201	201
Humboldt	6.59%	363	363	2,830	2,830	1,236	1,236
Imperial	5.83%	550	550	2,684	2,684	965	965
Inyo	4.62%	41	41	210	210	186	186
Kern	5.31%	426	1,526	1,192	10,687	1,519	4,162
Kings	5.78%	404	404	1,076	1,076	651	651
Lake	3.95%	85	85	420	420	548	548
Lassen	5.60%	108	108	796	796	255	255
Los Angeles	6.63%	9,101	26,474	81,365	276,735	27,710	74,726
Madera	5.10%	335	335	1,920	1,920	820	820
Marin	6.23%	202	539	2,409	7,508	999	2,543
Mariposa	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Mendocino	5.38%	227	227	1,524	1,524	756	756
Merced	5.85%	176	590	369	3,580	399	1,244
Modoc	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Mono	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Monterey	6.16%	441	1,153	3,690	10,633	1,174	2,949
Napa	4.95%	258	258	2,214	2,214	1,078	1,078
Nevada	4.34%	181	181	1,309	1,309	881	881
Orange	5.88%	1,896	6,068	19,996	70,567	6,919	18,804
Placer	4.93%	181	511	850	4,043	618	1,618
Plumas	4.61%	42	42	152	152	219	219
Riverside	5.00%	541	2,634	3,352	23,119	4,340	11,351
Sacramento	6.13%	1,146	3,170	8,213	29,524	3,657	9,551

Table 4 (cont'd): Unmet Need Estimate Based on Meinhardt's County-Specific Prevalence Rates

COUNTY	Prevalence Rate Used	18-20		21-59		60+	
		Lower Limit	Upper Limit	Lower Limit	Upper Limit	Lower Limit	Upper Limit
San Benito	5.39%	118	118	883	883	328	328
San Bernardino	5.49%	1,330	4,202	7,041	32,911	3,577	9,485
San Diego	6.35%	3,617	9,911	17,000	70,359	8,505	22,753
San Francisco	7.84%	0	849	1,624	22,329	2,041	8,740
San Joaquin	5.49%	509	1,464	258	8,785	810	3,315
San Luis Obispo	6.50%	449	1,177	1,828	6,301	1,098	2,745
San Mateo	5.43%	449	1,397	4,380	16,648	2,026	5,779
Santa Barbara	6.35%	328	1,320	2,193	9,814	1,372	3,708
Santa Clara	6.11%	1,519	4,184	15,558	49,099	4,050	11,689
Santa Cruz	6.26%	237	724	1,906	6,838	675	1,935
Shasta	5.21%	381	381	1,787	1,787	1,437	1,437
Sierra	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Siskiyou	4.67%	88	88	81	81	369	369
Solano	5.46%	314	960	2,151	8,550	760	2,172
Sonoma	5.42%	325	976	2,490	9,758	1,253	3,505
Stanislaus	5.37%	339	1,104	580	7,075	881	2,717
Sutter-Yuba	5.62%	385	385	2,452	2,452	1,037	1,037
Tehama	4.47%	110	110	337	337	449	449
Trinity	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Tulare	5.41%	393	1,103	1,366	6,594	878	2,408
Tuolumne	4.93%	100	100	486	486	479	479
Ventura	5.37%	658	1,847	5,339	17,320	1,780	4,879
Yolo	7.83%	1,218	1,218	4,455	4,455	1,363	1,363

DRAFT

Table 5: Unmet Need Estimate Based on CMHS Prevalence Rate

	18-20		21-59		60+	
COUNTY	Lower Limit	Upper Limit	Lower Limit	Upper Limit	Lower Limit	Upper Limit
Statewide	**28,888**	**76,889**	**191,913**	**699,403**	**92,042**	**225,145**
Alameda	1,102	3,103	9,923	34,242	3,689	9,725
Alpine	2	2	23	23	9	9
Amador	66	66	647	647	434	434
Butte	426	426	2,834	2,834	2,215	2,215
Calaveras	96	96	667	667	494	494
Colusa	58	58	319	319	147	147
Contra Costa	702	2,073	5,842	20,906	2,658	6,997
Del Norte	57	57	222	222	241	241
El Dorado	374	374	3,305	3,305	1,306	1,306
Fresno	455	1,867	955	12,677	1,623	4,860
Glenn	67	67	304	304	221	221
Humboldt	283	283	2,026	2,026	997	997
Imperial	505	505	2,396	2,396	885	885
Inyo	49	49	276	276	220	220
Kern	439	1,558	1,309	10,965	1,551	4,239
Kings	376	376	844	844	604	604
Lake	127	127	763	763	768	768
Lassen	103	103	757	757	246	246
Los Angeles	6,757	20,907	55,010	214,135	21,367	59,661
Madera	357	357	2,085	2,085	874	874
Marin	169	461	1,915	6,335	850	2,188
Mariposa	32	32	191	191	199	199
Mendocino	228	228	1,533	1,533	759	759
Merced	153	535	189	3,153	352	1,132
Modoc	25	25	80	80	103	103
Mono	19	19	244	244	65	65
Monterey	377	1,001	3,067	9,153	1,015	2,571
Napa	285	285	2,495	2,495	1,186	1,186
Nevada	231	231	1,757	1,757	1,109	1,109
Orange	1,648	5,479	16,994	63,437	6,214	17,129
Placer	204	565	1,071	4,568	688	1,782
Plumas	51	51	228	228	260	260
Riverside	663	2,923	4,502	25,850	4,748	12,320
Sacramento	971	2,754	6,367	25,141	3,146	8,339
San Benito	118	118	885	885	329	329
San Bernardino	1,296	4,121	6,733	32,178	3,506	9,318
San Diego	2,933	8,285	11,196	56,572	6,955	19,071
San Francisco	0	172	0	11,200	526	5,139
San Joaquin	497	1,437	156	8,544	780	3,244
San Luis Obispo	359	964	1,278	4,994	895	2,263
San Mateo	445	1,388	4,330	16,531	2,011	5,743
Santa Barbara	220	1,064	1,364	7,845	1,118	3,105
Santa Clara	1,294	3,649	12,724	42,367	3,404	10,156
Santa Cruz	189	608	1,413	5,668	549	1,636
Shasta	398	398	1,939	1,939	1,495	1,495
Sierra	7	7	44	44	37	37
Siskiyou	108	108	235	235	440	440
Solano	309	947	2,100	8,429	749	2,146
Sonoma	323	972	2,471	9,712	1,247	3,491
Stanislaus	342	1,111	606	7,138	888	2,735

Table 5 (cont'd): Unmet Need Estimate Based on CMHS Prevalence Rate

	18-20		21-59		60+	
COUNTY	Lower Limit	Upper Limit	Lower Limit	Upper Limit	Lower Limit	Upper Limit
Sutter-Yuba	369	369	2,307	2,307	991	991
Tehama	140	140	569	569	562	562
Trinity	38	38	154	154	145	145
Tulare	392	1,101	1,359	6,577	876	2,403
Tuolumne	114	114	609	609	537	537
Ventura	663	1,858	5,388	17,435	1,793	4,908
Yolo	877	877	2,913	2,913	966	966

estimates the 12-month prevalence rate of SMI to be 5.4 percent nationally (Center for Mental Health Services, 1999). The population figures for each age group (Table 3) were multiplied by 5.4 percent to provide another estimate of the number of adults and older adults with SMI (See Table 5).

Each prevalence estimate has benefits and limitations. The CMHS rate is more current. In addition, comparisons with other States are possible using this standard rate. The Meinhardt data are useful because the rates are adjusted to account for county-level socio-demographic information.

Number of Persons Needing Public Mental Health Services

As already mentioned, some persons with SMI receive services from private providers. The CMHPC believes that the DMH must commission a study to determine the percentage persons with SMI who rely on the public sector for services. Currently, Meinhardt et al.'s 1992 study provides the most accurate data applicable to California. In order to account for the changes to the system since that study, the CMHPC has provided a range for the number of persons needing public services. To find the lower end of the range, the estimated number of persons with SMI was multiplied by 42.1 percent, the proportion of adults expected to need public mental health services according to the Meinhardt study. The upper limit of the range is simply the estimated number of persons with SMI. This upper limit reflects the number of people who would need public services if no private services were available. For counties with populations under 200,000, a lower estimate was not calculated based on the assumption that a full range of private mental health services are not available in rural areas.

Unmet Need Calculation

The DMH provided the CMHPC with an unduplicated count of the number of clients served for fiscal year 1997-1998. In order to determine unmet need, the number of clients served was subtracted from both the lower end and the upper end of the estimated number of clients needing public mental health services. Tables 4 and 5 show the estimated range of clients suffering from SMI who are not receiving services. The unduplicated count of clients served excludes clients with only one outpatient visit or only one inpatient visit less than four days.

WHAT ARE THE LIMITATIONS OF THESE ESTIMATES?

Although the CMHPC tried to develop the most valid methodology possible given available data, any method for estimating unmet need has limitations that must be carefully considered when evaluating the results of the study. The following list enumerates those limitations.

1. Both the Meinhardt prevalence rates and the CMHS rate are derived from household surveys. As a result, they exclude the homeless and people in nursing homes, military barracks, correctional institutions, hospitals, and residential facilities for persons who are mentally ill or mentally retarded (Center for Mental Health Services, 1999, page 33895). Fischer and Breakey (1991) suggest that these groups constitute about five million people, or 2.7 percent of the U.S. adult population (Center for Mental Health Services, 1999). They estimate that the SMI prevalence rate for these groups is 50 percent. Because prevalence estimates do not include these segments of the population with the highest risk of SMI, the unmet need is underestimated.
2. San Francisco County has pointed out that a significant number of people drift in to the county after acquiring a mental illness. Forty-five percent of mental health clients admitted to the inpatient unit at San Francisco General Hospital had arrived in San Francisco within two months of the admission (Presson, 2000).
3. People who have a mental illness resulting from HIV infection may not be included in prevalence rates (Presson, 2000).
4. Ethnic populations may be hesitant to report mental illness and to seek services. Although the ECA study does account for differences in reporting rates for non-Hispanic whites and all ethnic minorities, it does not make more detailed distinctions. This study used prevalence rates based on the ECA catchment data rather than more recent studies done that estimate the prevalence of mental illness for each racial, ethnic, and cultural population.
5. Meinhardt's county-specific prevalence rates are based on the counties' 1980 socio-demographic variables. Because of the increase in population from 1980 to 1990, they required adjustment upward to reflect

increased population levels. This adjustment may not entirely account for differential migration by age and socio-demographic status (Meinhardt, 1990, page 17).

6. SED prevalence rates apply to children from 9 to 17 years of age. According to Friedman et al. (1996), "the data are presently inadequate to estimate prevalence rates for children under the age of nine" (page 84). Some studies have suggested prevalence rates of 7 to 22 percent for younger children (Knitzer, 2000). However, no reliable estimates are available for this age group. The CMHPC methodology most likely provides a conservative estimate for this age group.
7. Unmet need reflects the number of people who are not getting any mental health services at all. It does not reflect the number of people who are underserved.

Recommendation: Once the DMH completes the recommended study of access to private sector mental health services for each major ethnic group, the CMHPC should update the determination of unmet need generating estimates for each ethnic group using prevalence rates identified for those groups.

CHAPTER 4

THE PLANNED SYSTEM OF CARE FOR CHILDREN AND YOUTH[1]

The system of care for children and youth must reflect the fact that children and youth are different from adults. Children and youth, unlike adults, must negotiate a magnitude of developmental tasks resulting from their growth in physical, cognitive, social, and emotional domains. Therefore, the system of care for children and youth must promote their growth and natural development through both prevention services and treatment interventions. Another difference from adults is that children and youth are physically, emotionally, economically, and legally dependent upon adult family members and caretakers. Consequently, those adults must be part of service planning, treatment decisions, and long-term support.

WHAT ARE THE VISION, MISSION, AND VALUES FOR A SYSTEM OF CARE FOR CHILDREN AND YOUTH?

The mental health constituency envisions a society in which families[2] can raise happy, healthy, competent, and resilient children. The public mental health system promotes this vision through participation in a community-based system of care, which fosters optimal child development. The purpose of creating a public mental health system that collaborates with the larger children's system of care is to accomplish the following goals for children and their families:

- children are healthy;
- they are safe;
- they live at home;
- they are productive at school or at work;
- they have supportive relationships with others;
- they have meaningful connections to their communities; and
- they abide by the law.

The following values guide development and implementation of children's mental health services components within the larger system of care:

Access, voice, choice, and ownership. Children and their families should actively participate in and agree to all aspects of services they receive, including assessment, plan development, and treatment. They should participate in all aspects of policy development, program planning, services delivery, and oversight.

Cultural proficiency. Cultural proficiency of the system of care is essential to assuring access, voice, choice, and ownership to children and their families.

Early identification and intervention. Children with mental health needs should be identified early and provided with appropriate services. Serving infants and very young children at high risk of developing mental heath problems enhances the likelihood of positive outcomes in mother-infant bonding, family integration, and stability.

One family, one plan. All agencies involved with a child and family should join with the child and family to develop a single, coordinated service plan. Services should be delivered seamlessly with funding mechanisms invisible to the child and family.

The more complex the need, the more unique the response. Service plans should be individualized to meet the goals identified by the child and family while building on their strengths and resources. Families with the most complex needs should have services uniquely tailored to meet those needs.

Success is the only way out. Services should be unconditional with a no eject, no reject policy.

---

[1] The California Mental Health Planning Council (CMHPC) gratefully acknowledges the contributions of Charles Anders, Dave Neilsen, and Todd Sosna, Ph.D., to this chapter.

[2] The term, "family," is used in its broadest sense to include any adults who have legal responsibility for the care of a child, such as biological parents, foster parents, relatives, and other guardians.

DRAFT

Community based. All services, including residential, should be provided in the home community unless no appropriate local resources are available. Although some children and youth may require more restrictive care at various times, promptly returning them to a more natural environment should be one of the main goals of service planning.

School based. Schools are vitally important to all children and youth. School-based mental health services not only respond to the needs of identified children and youth but also can address the needs of children and youth identified as potentially high risk.

Recreation. Playing sports, socializing with peers, and engaging in other recreational activities are important to children's development. Providing children and youth with after-school and summer programs is an integral component of a system of care.

Natural supports. In working with families, the mental health system should assist them to identify and develop natural supports in the community.

Support for families. Families with children and youth with serious emotional disturbances need supportive services, such as education about serious emotional disturbances and mental illnesses, respite care, after-school care, crisis services, support for siblings, training in accessing public benefits, and peer support groups for parents and foster parents with similar problems.

Support during transitions. Transitions are challenging. For most children and youth, changes in routines are difficult, and they and their families need planned support during transitions between programs. Youth in transition to adulthood may need special services to assist them in making that transition successfully.

System accountability. Policies, programs, and services should be ethical, legal, effective, and cost effective. Accountability is provided by specifying measurable goals and through regular evaluation of policy, program, and service outcomes.

Basic rights. Children and youth with serious emotional disturbances have all rights, privileges, opportunities, and responsibilities accorded to other minors. Advocacy to protect and insure those rights and access to resources should be an integral part of the system of care.

Funding. State and local funding policies and mechanisms should support the concept of community-based systems of care. Fiscal incentives to mental health programs and other agencies should encourage the least restrictive, most appropriate services. Flexible funds should be available to allow special items or services to be purchased.

WHAT IS THE POPULATION TO BE SERVED?

A clearly identified target population has been a fundamental element of the system of care planning model since its inception in the mid-1980's. By using a focused definition of the target population, local mental health departments and other child-serving agencies were able to maximize their limited service capacity for a fairly narrow population of high-risk children and youth with serious emotional disturbances. Especially in the earlier years of system-of-care development, this service focuses on a small but well-defined target population proved effective in diverting children and youth from restrictive, high-cost group homes and returning them to their own families. This initial success both demonstrated the increased relevancy of mental health services to other child-serving agencies and established local mental health departments as a key partner in building effective collaborations among public agencies.

In the initial stages of children's system-of-care development, this narrowly defined target population was placed in statute as the group with the highest priority for receiving services. Now, fifteen years later, nearly all county mental health programs in the State are funded for children's system-of-care development. The relevance of mental health services to public partner agencies and the access those agencies have to mental health services for their children and families is once again being examined. The historical children's system of care "target population" has become less critical as a screening tool due to stabilized funding for community mental health programs. At the same time, new evidence suggests that significant improvement in child and family well being can be achieved through providing appropriate mental health services. For example, major initiatives launched by the Department of Social Services and probation agencies are highly dependent upon the successful integration of specialty mental health services into service plans for at-risk children and youth. In addition, new initiatives from entities outside traditional system-of-care partners, such as Healthy Families,

have received much public attention in the field of services to children. These initiatives underscore the need for expanding the involvement of the public mental health system to a broader range of children, youth, and families.

Over the preceding decade, these growth areas have taken center stage. Not all localities have effectively integrated these successive initiatives into the existing system of care to create a "seamless system" for children and their families. This piecemeal approach to service expansion has often resulted in counties perceiving no clear fiscal incentives that direct mental health leadership to broaden the system-of-care target population to include children served by partner agencies. As a result, services provided through these other funding streams are not necessarily governed by system of care principles.

The population to be served by the children's system of care should include all children who receive services from the primary child-serving public agencies, including those children who are potentially eligible for services, such as children who are at risk of out-of-home placement. Priority should be placed on early identification of children and youth at risk so that their symptoms do not become so severe that they require more intensive service. Mental health services should be delivered to this expanded system-of-care population so that these children might be spared a whole array of negative life outcomes, including out-of-home placement, juvenile justice involvement, and school failure.

WHY DOES A SYSTEM OF CARE WORK AND HOW IS IT STRUCTURED?

California is a national leader in promoting mental health systems of care for children and their families. The system of care and its required components are specified in state legislation. Required components in a system of care include family partnership, cultural proficiency, a full continuum of community-based services and supports, cross-agency collaboration, and evaluation of outcomes. However, the manner in which children's system of care components is expected to address these requirements is not detailed. The success of systems of care is, in part, responsible for collaborative programs being promoted by other service systems, including child welfare, juvenile justice, schools, and public health. However, many communities have service delivery systems made up of collaborative, but fragmented, programs. This fragmentation typically results form rapid expansion and hurried strategic planning. In addition, the local collaboration sometimes loses its focus on how to integrate all these efforts.

Goodness of Fit Theory of Change

Mental health is critical to a person's success as an individual, a family member, and as part of the community. Mental health is necessary for critical functions, such as motivation, planning, learning from the consequences of one's actions, impulse control, social interactions, empathy, and altruism. Impairment in these important functions can result in severe impairment in many areas, such as employment; raising children; getting along with others; meeting basic needs for food, shelter, health, and clothing; learning in school; and abiding by the law. Public agencies have been established with dedicated resources and specialized staffing and expertise to address problems, such as homelessness, unemployment, child abuse and neglect, crime, access to health care, and failure to benefit from schooling. Specific services and programs available from county mental health departments are described in the appendix to this chapter.

Each of these agencies is successful with many of the children and families that they serve; however, a small percentage of children and families are not successful despite receiving services from the responsible agencies. This small percentage of children and families tend to account for a disproportionately large percentage of need. Failure to benefit from typical services offered by the responsible agencies can be explained by the profound effects of mental disorders and substance abuse. As a consequence, success with these children and families will require the combined efforts of several agencies working to address areas of impairment and underlying mental health disorders.

The children's system of care needs "theory of change" that explains why these components individually or in combination will result in better outcomes for children and families. The relevance and significance of theories of change for collaborative programs is profound. Collaborative programs are formed to achieve better child and family outcomes at the same or lower cost. Collaboratives are successful when members of the collaborative work in concert to build on each other's strengths, resulting in a product that is greater than the sum of its parts. Collaboratives benefit from the enhanced decision making that results from teamwork. In order for a collaborative to make decisions successfully, the team benefits from having a shared theory of change that is a composite of the approaches that characterize the agencies that form the collaborative. The

"goodness of fit" theory of change offers tremendous promise for children's mental health systems of care as well as collaboratives being promoted in other service systems.

The benefits of the children's mental health systems of care as well as similar reforms promoted by child welfare and juvenile justice systems (e.g. wraparound, family unity, and family group conferencing) can be explained by a "goodness of fit" theory. This theory is premised on individualized care that builds on child and family strengths. The term, goodness of fit, means that the services provided to a child and family fit well with their strengths and needs. This theory provides plausible explanations for why the systems of care are needed and why they work.

The best outcomes in terms of both child and family functioning and cost are directly related to the goodness of fit between child and family strengths and needs and the level of care provided. In the absence of an appropriate and precise fit, a child will be over- or underserved. Imprecision or mismatch in service level is directly related to unachieved outcomes and waste.

The adverse consequences of over-serving include:

- limited positive outcomes;
- exposing a child and family to overly intrusive and restrictive interventions;
- unnecessary costs;
- fostering dependence on service providers; and
- undermining child and family autonomy.

The adverse consequences of under-serving include:

- absence of positive outcomes;
- wasted expenditure of time and resources;
- unrealized hopes; and
- loss of confidence in effectiveness of future interventions.

Achieving a good fit requires building on child and family strengths to promote meeting their needs and achieving their goals. The importance of each component of a system of care described below can be understood in terms of its relation to promoting strengths-based, individualized care or "goodness of fit:"

- **Family partnership** is necessary to identify child and family strengths and the goals of the child and family and to promote hope, child and family participation, and sharing of information.
- **Collaboration** is necessary to promote coordination of care across agencies, access to cross-agency services, and expansion of the local continuum of care and to improve planning through cross-agency and interdisciplinary expertise.
- **A full continuum of community-based services and supports** is necessary to promote access, to build on family and community strengths and resources, and to improve generalization of gains.
- **Evaluation of outcomes** is necessary to promote informed decision-making about services and systems change, and to improve quality of care, advocacy, and sustainability of effective service delivery reforms.

Structure of the Children's System of Care

To implement individualized, strengths-based services, a system of care must have certain physical elements to perform its various functions. These functions include identifying children who need an individualized service plan, designing the interagency service delivery system, developing programs and services, providing individualized service planning and implementation, ensuring family member participation, and conducting system evaluation. These functions should be performed by the individual agencies participating in the children's system of care, the interagency policy council, the interagency case management committee, service providers, and an evaluator. This section describes these physical elements and the functions they perform in the children's system of care.

The interagency policy council designs and guides the children's system of care. The director of each child-serving agency in the county and senior management staff should participate in the interagency policy council. The interagency policy council performs the same functions for the children's system of care that an agency director performs for his or her own agency. These functions include developing a vision for the system and

imparting that vision to staff; designing new interagency programs and services; designing the manner in which children enter the system, receive services, and exit the system; and monitoring the system to improve performance.

The system must include a process for identifying and referring children and their families who need an individualized service plan to experience positive outcomes. The system of care should develop a screening tool that identifies those children who are most likely to experience poor outcomes if served by the traditional service delivery system. The traditional delivery system refers to a single child-serving agency providing just its services to a child and family as opposed to multi-agency interventions for children and families with more complex needs. The children and families that come into contact with a public agency should be screened by that public agency and referred to either a single child-serving agency for traditional intervention or to the interagency case management committee to develop an individualized service plan.

The interagency case management committee includes staff from the major child serving agencies. The staff should have the authority to commit resources to a service plan. The interagency case management committee is responsible for developing and implementing the individualized service plan for the children and families who are referred to them. Families are referred to the interagency case management committee because they need services from more than one child-serving agency in the county.

Separate from the service planning and implementation process is an evaluation component. The children's system of care should employ an evaluator to monitor staff fidelity to the service planning and implementation process and to evaluate outcomes for children and their families. This information must be fed back to management so that it can improve service planning and delivery. The information must also be fed back to the interagency policy council so that it can improve adherence to system processes or adjust system processes to improve outcomes.

The children's system of care must also have family members and youth involved at the policy level, in service planning and implementation, and the evaluation process. The service delivery system is designed to meet the needs of children, youth, and their families. Family members have first hand knowledge about what is and is not effective at the system and service delivery level. This input must be valued and incorporated into designing and operating the children's system of care. This type of information will help the evaluator better identify what needs to be evaluated as well as how to best implement the evaluation process to include other family members.

So far, this discussion has focused on formal elements of the system of care, such as service providers and county infrastructure for implementing the system of care approach. Of equal importance are the informal elements for supporting children and families in the community. These informal elements are sometimes referred to as natural supports and include extended family, churches, neighbors, schools, mentors, and co-workers.

Figure 1 clarifies the relationship of the formal and informal partners in a system of care. At the center of the system of care is the child, surrounded by the immediate family. This circle forms the heart of a family's support system. Extended family, friends, and neighbors are in the next two rings of the circle. These individuals are informal sources of support that a family can rely on when it needs assistance. Other natural resources, such as schools and faith communities, surround this group. The next circle represents the formal resources provided by public agencies. Finally, in the outermost circle are state and federal agencies that provide the statutory and fiscal framework for the formal support agencies. When children and their families need assistance, they use available resources in ever widening circles. A system of care will assist families to strengthen their natural resources so they can rely on informal supports, eventually reducing the need for public agency involvement.

Interagency Context for the System of Care

Like any system, changes in any of the sub-systems have repercussions on the rest of the system. Therefore, a major shift in funding, mandate, entitlement, or policy will affect all of the major partners. A system of care involves interdependency between the primary child-serving agencies. Consequently, the system's leaders must be aware of current challenges facing each of the agencies.

Some of the partner agencies in the children's system of care are facing significant challenges. In education, class size reductions have resulted in a shortage of space for support staff, special education classes, and

DRAFT

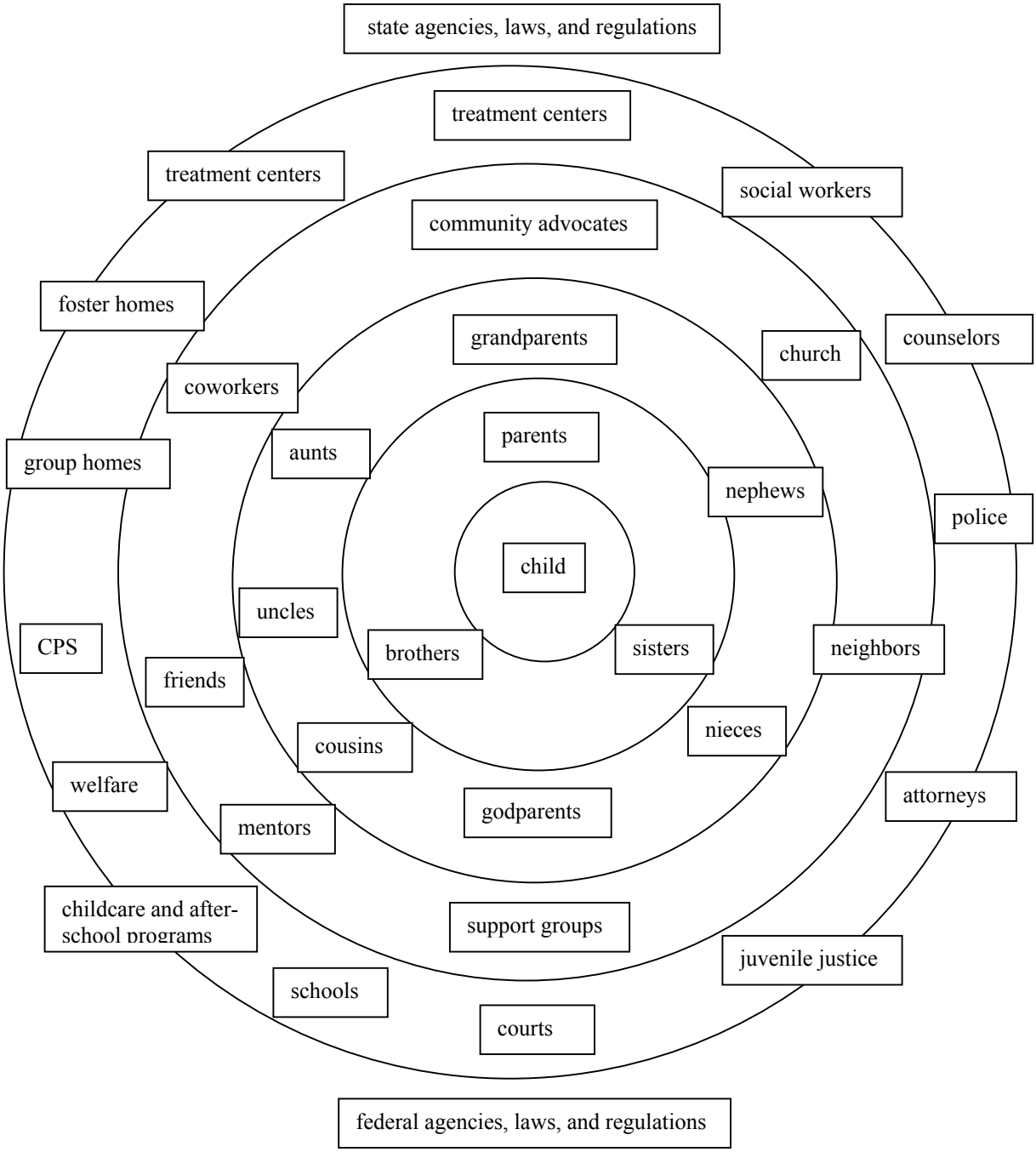

Figure 1: Formal and Informal Partners in the System of Care

collaborative agencies, such as mental health, probation, and social services staff. Schools are dealing with increasing pressure to improve standardized achievement test results. This pressure is contributing to a move toward "zero tolerance," ejection of students who misbehave sometimes for relatively minor infractions. Suspending or expelling students from school can create behavioral problems that put pressure on their families and other child-serving agencies. In the child welfare system, placements have risen with particular pressure on the most intensive level of placement: RCL 12-14. In the mental health system, Metropolitan State Hospital is now the only state hospital available for children. Community treatment facilities, which would provide secure placement options, are available only to a limited degree. Recent legislation requires that the Interstate Compact Placement Committee rigorously screen out-of-state placements by child welfare and juvenile probation. Mental health placements do not have this requirement, which puts additional pressure on children to be placed through the Chapter 26.5 process so that very disturbed children who are in need of contained settings can receive an appropriate placement.

These examples illustrate some of the pressures existing among child-serving agencies and the potential for cost-shifting and transferring responsibility for the care and treatment of children among those agencies. A better strategy would be one in which a county as an administrative unit has ultimate responsibility for the clinical and fiscal outcome for children and their families. The concept of a larger system of care is based on shifting the point of responsibility from the individual child-serving agencies to the county level. The high degree of interdependency among agencies means that one agency cannot excel in achieving good outcomes unless it works collaboratively with other agencies to achieve goals that have been established in common. The locus of responsibility for managing care should be at the level of the county governing body. At that level, the goals are protection of the county general fund and improvement of community well being. One of the strategies for achieving those goals is to improve outcomes for children and youth who are potentially high risk and high cost. Implementation of this approach has implications for increased partnership, particularly with education, but also with informal supports for families, such as the faith community and grassroots organizations.

WHAT INNOVATIVE PROGRAMS HAVE BEEN DEVELOPED FOR CHILDREN?

Federal, state, and county governments have been developing innovative programs that are consistent with the vision, mission, and goals of the children's system of care. This section highlights those initiatives.

Wraparound Services

Chapter 795, Statutes of 1997, (SB 163), allows counties in California to participate in a five-year pilot project. The purpose of the pilot project is to provide eligible children with family-based service alternatives to group home care. The wraparound pilot project focuses on a family-centered, strengths-based, needs-driven planning process for creating individualized services and supports for children, youth, and their families. These services facilitate access to normalized and inclusive community options, activities, and opportunities. The legislation permits flexible use of state foster care funds and Adoption Assistance Program funds to pay for individualized, intensive wraparound services necessary to keep these children in family settings or to return them to families. The legislation targets children who are currently residing in or are at risk of being placed in the highest levels of group home care.

Following are ten essential elements of wraparound services: (adapted from Burns and Goldman, 1998)

1. Families have a high level of decision-making power at every level of the wraparound process.
2. Team members persevere in their commitment to the child and family.
3. Wraparound efforts are based in the community and encourage the family's use of their natural supports and resources.
4. The wraparound approach is a team-driven process involving the family, child, natural supports, agencies, and community services working together to develop, implement, and evaluate the individualized service plan.
5. Services and supports are individualized, building on strengths and meeting the needs of children and families across the life domains to promote success, safety, and permanency in home, school, and the community.

6. The process is culturally competent, building on the unique values, preferences, and strengths of children, families, and their communities.
7. The plan is developed and implemented based on an interagency collaborative process with the community or neighborhood.
8. Wraparound plans include a balance of formal services and informal community and family resources, with eventually greater reliance on informal services.
9. Wraparound teams have adequate and flexible funding.
10. Outcomes are determined and measured for the system, for the program, and for the individual child and family.

Balanced and Restorative Justice

Restorative justice is defined as a process whereby parties with a stake in a specific offense decide collectively how to deal with the aftermath of an offense and its implications for the future. Acknowledging that crime causes injury to people and communities, restorative justice aims to repair those injuries and enables the parties to participate in that process. Restorative justice programs, therefore, enable the victim, the offender, and affected members of the community to be directly involved in responding to the crime. They become central to the criminal justice process with state and legal professionals becoming facilitators of a system that aims at offender accountability; reparation to the victim; and full participation by the victim, offender, and community (Van Ness, 2000).

Restorative justice is different from contemporary criminal justice in several ways. First, it views criminal acts more comprehensively. Rather than defining crime as simply lawbreaking, it recognizes that offenders harm victims, communities, and themselves. Second, it involves more parties in responding to crime. Rather than giving key roles only to government and the offender, it includes victims and communities as well. Finally, it measures success differently. Rather than measuring how much punishment is inflicted, it measures how many harms are repaired or prevented (Van Ness, 2000).

The National Center for State Courts reported that implementing a restorative justice approach is a major trend in the juvenile justice system, especially in Pennsylvania, Florida, and Minnesota (National Center for State Courts, 1998). Some counties in California, such as Shasta and Santa Cruz, are also implementing this approach to juvenile justice. A restorative justice approach provides a framework for systematic reform and offers hope for preserving and revitalizing the juvenile justice system. Implementing this new approach involves developing new missions and goals for juvenile justice; reallocating resources; redesigning job descriptions; developing new reporting measures and data collection systems to monitor effectiveness; giving priority to new programs and practices; and developing new roles for victims, citizens, and offenders in the justice process (Bazemore, 1997).

Challenge Grants

The Juvenile Crime Enforcement and Accountability Challenge Grant Program is administered by the Board of Corrections. The purpose of this program is to reduce juvenile crime and delinquency. Counties were awarded grants based on developing and implementing a comprehensive, multiagency action plan that provides for a continuum of responses to juvenile crime and delinquency. Counties also needed to demonstrate a collaborative and integrated approach for implementing a system of swift, certain, graduated responses and appropriate sanctions for at-risk youth and juvenile offenders.

To be eligible for a grant, a county must establish a multiagency juvenile justice coordinating council that develops and implements a continuum of county-based responses to juvenile crime. The coordinating councils develop a comprehensive, multiagency plan that identifies the resources and strategies for providing an effective continuum of responses for prevention, intervention, supervision, treatment, and incarceration of juvenile offenders, including strategies to develop and implement locally based or regionally based out-of-home placement options for youth.

Counties receiving grants are also required to identify outcome measures, including the rate of juvenile arrests, the rate of successful completion of probation, and the rate of successful completion of restitution and court-ordered community service responsibilities.

Healthy Families

The Healthy Families Program provides low-cost health insurance for uninsured children and youth up to their 19th birthday who are not eligible for no-cost, full-scope federal Medi-Cal and whose family incomes are below 250 percent of the federal poverty level. The Healthy Families Program provides health, dental, and vision coverage. For mental health services, the health plans are responsible for 20 outpatient visits per year for evaluation, crisis, and treatment for conditions that can benefit from relatively short-term intervention and 30 days of inpatient care. The health plan is also responsible for medication and laboratory services to treat those mental conditions.

Children with serious emotional disturbance enrolled in the program can receive additional mental health services. Upon determination by a county mental health program that an enrollee has a serious emotional disturbance, the full range of medically necessary services available through the Medi-Cal Rehabilitation Option and Targeted Case Management programs will be provided to the extent resources are available.

Healthy Start

The Healthy Start Support Services for Children Act (SB 620, Presley, 1991) is California's first statewide effort to place comprehensive support services for children and families at school sites. Healthy Start brings together schools, school districts, county offices of education, health and human services agencies, county governments, nonprofit organizations, businesses, and others to focus their collective energy, expertise, and resources on responding to the needs presented by children, youth, and families in the school community. The intent of Healthy Start is to improve the lives of children and families by the following actions:

- creating learning environments that are optimally responsive to the physical, emotional, and intellectual needs of each child;
- fostering local interagency collaboration and communication to deliver education and support services more effectively to children and their families;
- encouraging the full use of existing agencies, professional personnel, and public and private funds to ensure that children are ready and able to learn, and to prevent duplication of services and unnecessary expenditures; and
- building on the strengths of children and families and providing and enhancing opportunities for parents and children to be participants, leaders, and decision-makers in their communities.

Healthy Start does not necessarily pay for services. Rather, it provides coordinated service delivery that links children and families to needed supports and services. These school-linked supports and services that are being offered to meet the needs of Healthy Start children, youth, and families include:

- child protection, parenting education, and child care;
- food, clothing, shelter, and transportation;
- vision care, hearing, dental care, acute care, and preventive health care;
- therapy, support groups, and substance abuse services;
- tutoring and dropout prevention;
- career counseling, job placement, and job training;
- recreation and youth development; and
- income maintenance through Medi-Cal, Temporary Assistance for Needy Families, and food stamps.

The first statewide evaluation revealed that from January 1993 through March 1995 schools experienced statistically significant schoolwide improvements in standardized test scores for grades one through three, increased parent participation, and reductions in student mobility. Children and families intensively served through Healthy Start showed improved results in every area examined.

WHAT POPULATIONS NEED SPECIAL ATTENTION?

Although the California public mental health system has made great strides in the last 15 years developing a children's system of care, specific sub-populations should be examined to ensure that children, youth, and families benefit from the system-of-care outcomes. This section identifies those sub-populations with emergent needs for mental health services.

Gender Issues

In 1999, the California Institute for Mental Health issued a report on issues related to mental health services and treatment for women. This report highlighted the needs of young girls, which are not addressed by the children's system of care. The report states, "Current practice frequently discounts the significance of gender-linked issues such as abuse and trauma, and allocates insufficient attention and resources to mental health problems most prevalent among women, such as eating disorders, depression, and post-traumatic stress disorder" (California Institute for Mental Health, 1999), (p. 7). To redress this imbalance in the system of care, county mental health departments should develop early identification and intervention strategies designed to reduce development of more serious mental health problems.

Another problem that the report identifies is that, in counties funded by the State's children's system of care grants, more boys than girls are receiving services. The report speculates that this imbalance may have results from the need to prioritize mental health services due to inadequate funding. Boys tend to exhibit problems related to externalizing behaviors, such as aggression; girls tend to have internalizing problems, such as depression. When determining who has the greatest need of services, clinicians would most likely identify externalizing problems as having higher priority. Now that the children's system of care has access to additional funding through EPSDT, clinicians need to assure that the mental health needs of young girls are addressed.

Children Age 0-5

The National Institute of Mental Health estimates that at least 7.5 million children have diagnosable psychological disorders that significantly affect the quality of their lives. Research has demonstrated the powerful role that early identification, intervention, and meaningful support and assistance can have for these children and their families. This knowledge has led to increasing awareness of the factors that contribute to adaptive and maladaptive patterns of development in infants (California Infant Mental Health Work Group, 1996).

The brain research literature provides striking evidence that an early focus on children can pay big dividends later in life. These findings support the idea that, although the shaping of the brain continues long after birth, the first years are critical for the full development of a child's cognitive abilities. Research on brain development provides important support to the research examining the relationship between family risk factors during childhood and poor life outcomes for children in such environments. These bodies of research point to ways in which families and society can ameliorate the effects of environmental stress on children (Illig,).

Infant mental health refers to a comprehensive perspective on social and emotional well being in infants and toddlers and the processes that support it. Infant mental health depends upon a number of factors, including the interactions between parents and a child and the child's relationships with other caregivers and siblings (California Infant Mental Health Work Group, 1996). Through positive interactions, the infant acquires pleasurable feeling about self and others; the capacity to relate to others; feelings of value and self-worth; a sense of having an impact on one's world; and a sense of belonging to family and community. The basic foundations of infant mental health include:

- parent-infant-family attachments and positive interactions;
- caregiver capacity to read and respond to infant cues;
- infant capacity to initiate and respond to caregiver interactions;
- availability of social supports; and
- parental capacity to use social supports (California Infant Mental Health Work Group, 1996).

The infant and family well being can be affected by vulnerabilities within the family environment, such as poverty, biological and health factors, substance abuse, domestic discord, community violence, and other stress factors (California Infant Mental Health Work Group, 1996). Infants are born to parents with a range of capacities to initiate and respond to all aspects of their environment. Thus, a continuum of interventions must be available ranging from promotion of best parenting practices, anticipatory guidance, and development of parenting skills to critical interventions with severely dysfunctional infants and their families (California Infant Mental Health Work Group, 1996).

Delivery of effective, family centered infant/toddler mental health services is dependent on well-trained health, mental health, education, developmental services, and social services professionals. Staff should be

experienced in the care of children from birth to three years of age, able to facilitate child/caregiver relationships, assist in positive behavioral development, and provide grief and crisis counseling.

To expand the capacity of the public mental health system to serve this population, the Department of Mental Health (DMH) funded four counties as a pilot project. This initial effort is now being expanded due to an award of $3.6 million from Proposition 10's California Children and Families Commission. The framework and funding for the Infant Family Mental Health Initiative is based on existing efforts in training, model development, capacity building, and evaluation of the Infant Mental Health Development Project funded by the Department of Developmental Services and coordinated by West Ed/CEITAN.

The goals of the Infant Family Mental Health Initiative are to:

- identify the early childhood/infant and family mental health needs, resources, and services within pilot counties;
- increase the capacity of county mental health departments to identify and serve very young children and their families;
- facilitate interdisciplinary and interagency collaboration for services and staff training;
- provide models, resources, funding options, and replicable approaches for the delivery of effective mental health services for infants and their families.

Evaluation is a significant part of this initiative and will involve developing procedures for both ongoing and overall evaluation of project outcomes, including:

- the results of a feasibility study based on screening and treating 10 infants and families in each county;
- changes in service delivery;
- personnel development;
- county capacity to provide infant-family mental health services; and
- staff training and supervision.

Youth in the Juvenile Justice System

Studies have shown that children in the juvenile justice system have high rates of mental illness (Evens, 1997). The prevalence of mental disorders among youth in juvenile justice facilities ranges from 50 to 75 percent in multiple, well-designed studies that used structured diagnostic interviewing techniques to determine children's diagnoses (National Mental Health Association, 1999). However, youth in the juvenile justice system, especially those incarcerated in juvenile halls, face substantial barriers to receiving mental health services. Medi-Cal reimbursement is only available for youth in juvenile halls who have been adjudicated and are awaiting placement. Other youth in juvenile halls are not eligible for Medi-Cal; consequently, many counties are not able to fund the needed mental health services for these youth. Moreover, juvenile halls and the California Youth Authority are experiencing widespread over-crowding. Case loads for juvenile probation officers are often high, precluding the ability to provide individualized services involving the family. An overriding concern is that youth suffering from mental illness who have been incarcerated do not have access to adequate mental health services.

Child Care and After-school Care

Children with serious mental health needs generally exhibit behaviors related to their condition at child care and after-school care. In fact, such conditions may first be manifested in these settings. The children's symptoms and behaviors often result in frustration for the care provider who usually has had no training in identifying serious emotional disturbances or the skills for responding constructively to the child's needs. If the symptoms include aggressive, acting out behavior, the child is typically expelled by the care provider. This expulsion adds pressure to a family system that is likely struggling with the same behaviors. Such expulsions and loss of continuity result in increased stress to the child and further exacerbate the child's and family's difficulties.

Child care and after-school care are an ideal places for early identification of serious emotional disturbances and intervention. Ideally, through training in mental health identification and referral and ongoing support, care providers will be able to maintain more children with serious emotional disturbances in their current care situations. At the same time the care provider will learn techniques and gain understanding that will benefit all children in the provider's care.

Youth with Dual Diagnoses

All children and youth should be screened for potential alcohol and other drug use. If such use is identified, a substance use assessment should be completed, and a substance abuse treatment plan should be coordinated with the mental health plan, integrating mental health and drug and alcohol treatment. This combined treatment approach may require cross-training in screening, assessment, and treatment for mental health and alcohol and other drug staff as well as for education, probation, and other child serving agencies.

Results from the DMH's performance outcome system show that clinicians are reporting that approximately 15 percent of the youth they assess have moderate to severe impairment regarding substance use. However, estimates of national studies of co-occurring mental disorder and substance abuse among adolescents range from 22 to 82 percent (Substance Abuse and Mental Health Administration, 1999). The prevalence of co-occurring emotional and behavioral problems and addictive disorders varies across studies because of methodological complexities of studying this issue. However, this study by the Substance Abuse and Mental Health Administration (SAMHSA) also cites evidence that over 30 percent of 16 to 17 year olds report using alcohol in the past month with past-month alcohol use being nearly twice as likely for adolescents with serious emotional disturbances. Dependence on substances, such as cocaine, crack, inhalants, hallucinogens, heroin, or abused prescription drugs was nearly 9 times as likely among adolescents with serious behavioral problems. Comparing national estimates of co-occurring emotional and behavioral problems and addictive disorders with results from California's performance outcome data on children and youth, suggests that mental health clinicians may not be identifying all youth with substance abuse problems.

The need to diagnose substance use disorders among youth with serious emotional disturbances is underscored by the increased incidence of suicide among adolescents and young adults. In 1997, suicide was the third leading cause of death for persons age10 to 24. Annual surveys indicate that up to 7 percent of high school youth have attempted suicide. Co-occurring mental and substance use disorders have been identified as precursors and risk factors for youth suicidal behavior. For adolescent males who complete suicide, comorbid conduct disorder, mood disorder, and substance use disorder are the most common diagnoses. For adolescent females, mood disorders predominate with lower rates of comorbid substance use disorders and conduct disorders compared to adolescent males. (National Institute of Mental Health and National Institute of Drug Abuse, 2000)

Transition-age Youth

The upper age limit for youth eligible for services in the children's system of care varies based on the funding source for the individual child. Children generally move to the adult system at age 18. Medi-Cal eligibility for some youth continues past age 18 because they are eligible for Supplemental Security Income or Temporary Assistance to Needy Families or because of their status as a child formerly in foster care. These youth are eligible for Medi-Cal funded mental health services up to age 21. Those with Healthy Families insurance can receive services through that source until age 22. Finally, students eligible for services through Chapter 26.5 are generally eligible for those services until they graduate from high school, get a General Education Diploma, or reach age 22, whichever comes first.

When youth with mental health needs become too old for services from the children's system of care, they often face overwhelming obstacles making a successful transition to adulthood. In disproportionate numbers, they become pregnant or develop substance abuse problems. Homelessness is also a significant risk for many youth with mental health conditions. They often try unsuccessfully to live with their families, then turn to living with friends in unstable arrangements, and too often end up in jail, the hospital, or homeless.

Like all young people, youth with mental health problems need assistance with income, safe and affordable housing, independent living skills, and educational and vocational planning. They also need assistance learning and integrating social skills and finding appropriate social activities and relationships. As they develop their identities, they need to experiment with different lifestyles and choices, sometimes making mistakes, which teach life lessons. Unlike other youth, they need mental health services and must manage their symptoms while moving to independence. Some have little or no support from parents. Research has shown that mentoring is a powerful force in the lives of young people, especially those who have a disrupted relationship with parents.

Education for these youth is often interrupted and disjointed. Many do not reach their educational potential due to multiple changes in schools, including enrollment in special education and non-public school classes. They need support in the most normative educational settings possible. Innovative programs with community

colleges can provide a welcome second chance in an environment more accepting of diversity than are the public school systems.

Employment for young people can be a stabilizing and normalizing activity, providing the opportunity to learn work skills and identify interests and to see themselves as successful members of mainstream adult society. Youth need vocational counseling, job placement, and job coaching to choose, get, and keep desirable employment.

Peer relationships are important for adolescents and young adults as they separate from adult caretakers and develop their identity. Youth this age often need and welcome assistance with learning how to make and keep friends, how to form successful intimate relationships, how to develop a satisfying social life, and how to manage their emotions.

Transition-age youth are sensitive to the stigma attached to having a psychiatric disability. They generally prefer to have opportunities to participate in the normal activities of this age: attending school, dating, driving, working, and living in a place of their own. These wishes should be respected.

When providing services to youth in transition, the following guiding principles should be followed:

1. A single service coordinator should follow transition-age youth who are at risk of homelessness until age 25.

2. Clients should not be rejected or ejected from services for exhibiting the symptoms of their illness or for the experimentation that is a hallmark of this developmental stage.

3. Services should be provided in the community or at clients' homes, according to the preference and convenience of the client.

4. Peer support, self-help groups, and mentoring are essential to successful transition-age services.

5. All staff who work with transition-age youth should be trained in the developmental needs of this population, in community resources, and in operationalizing a recovery philosophy.

To meet the needs of these youth, mental health programs must work in partnership with the following child-serving agencies and adult agencies:

- employment and training agencies;
- independent living programs;
- the systems of care for children and adults;
- court advocates;
- probation;
- housing and redevelopment departments;
- homeless programs;
- County Offices of Education and school districts; and
- community college districts.

WHAT ARE THE BARRIERS TO EFFECTIVE OPERATION OF THE SYSTEM OF CARE?

Lack of State Level Coordination

Structures for interagency collaboration have been created at the county level; however, interagency coordination at the state level has never been addressed effectively. Over the past few years, interest in providing services to children and their families has increased dramatically. These initiatives have been developed by diverse state departments and agencies. For example, the Department of Social Services within the Health and Human Services Agency has responsibility for innovative wraparound programs for children at risk of out-of-home placement. The DMH administers many children's programs, including the system of care allocations. The Board of Prison Terms in the Youth and Adult Corrections Agency administers the probation challenge grants. The Department of Education has responsibility for the Healthy Start program administered through the school districts.

Although all these programs are very beneficial to children and their families, they also create challenges to local agencies due to incompatible administrative requirements that occur because the various state agencies do

not work together to develop compatible programs. Moreover, these programs can also be burdensome to family members, who may be put in the position of having to provide duplicative information on the functioning of their children for assessment, treatment planning, and program evaluation purposes.

To address these concerns, the State should establish a Children's Council that would have the following goals:

- establish a common vision for services to children and their families;
- ensure collaboration among state agencies and departments; and
- establish a common data set and local accountability for child and family services.

Membership should include:

- Secretary, Health and Human Services;
- Chair, Board of Corrections;
- State Superintendent of Public Instruction;
- Governor's Education Advisor;
- County Supervisors Association of California;
- Judicial Council;
- Secretary, Youth, Adult, and Correctional Agency;
- Chief Probation Officer representative;
- Attorney General;
- Juvenile Justice Commissioners; and
- Parent and youth representatives.

Many state policies and programs are actually implemented on the local level by county agencies. To assure that coordinated state initiatives are implemented with maximum collaboration at the local level, the Children's Council of Statewide Associations should also be established. The purpose of the association would be to develop a shared vision and operationalize it through the following methods:

- education and technical assistance;
- cross-training among local agencies;
- convening joint conferences and scheduling joint committee meetings; and
- blending outcomes, funding, and the populations to be served.

Membership should include:

- Chief Probation Officers of California;
- California Conference of Local Health Officers;
- County Health Executives Association of California;
- County Alcohol and Drug Program Administrators Association of California;
- County Mental Health Directors Association;
- Child Welfare Directors Association;
- Special Education Local Plan Area Directors Association; and
- Families and Youth.

Flexible Use of Funds for Improved Child Outcomes

Improving access to necessary resources will help to ensure the success of children and families. One of the unintended outcomes of years of specifically focused funding streams has been the "barriers" created by the inability to develop "blended funding streams" that complement the service system integration efforts. Examples of this complex funding for children's mental health services include these sources:

- Medi-Cal, including EPSDT, and managed care consolidation;
- Chapter 26.5 (AB 3632);
- Allocations from the SAMHSA Block Grant;
- Healthy Families;
- DMH's children's system of care allocations;
- Realignment; and
- Other federal grants.

Additional fiscal resources for children include federal, state, and local public and private funds in various forms, such as the Supportive and Therapeutic Options Program (STOP) funds, Temporary Assistance for Needy Families, CalWorks, Probation Challenge Grants, special education, Healthy Start, SB 163 /Foster Care Waiver funds, grants, pilot projects, and other targeted funds that must be woven into the system of care.

Public funding for services for children tends to be categorical; that is, it is available through mandates or programs for the exclusive use of a relatively narrowly defined population. These funds are available for only a specific set of services rather than for any services appropriate to the needs of a child and family. Examples of categorical funding are Chapter 26.5 funds, which are entitlements for students who have been found to require mental health services in order to benefit from their educational program. Another example is Medi-Cal funds, an entitlement for children under the age of 21 who are Medi-Cal eligible and who have a mental health diagnosis. Healthy Families is for children who do not qualify for Medi-Cal but who live in families whose income is below 250 percent of the poverty rate.

Categorical funding is like a puzzle with some pieces missing: if a child or group of children does not fit into any of these categories, the only option is to fund services through county realignment funds. To protect these scarce non-categorical resources, a county may be forced to have a different, narrower set of criteria for services and a more limited range of service options for these children than for children eligible for services through Medi-Cal or Chapter 26.5.

Problems resulting from categorical funding are also evident when children are in need of out-of-home placement. Placement in a group home will be paid for by public funds if a child has been made a dependent of the court because of abuse or neglect by a parent or caretaker, has been made a ward of the court because the child has broken the law and is under the supervision of the Probation Department, or is eligible for services under Chapter 26.5. To be eligible for services under Chapter 26.5, a child must need a mental health service in order to benefit from their education.

If a child does not meet any of these conditions and the parents cannot afford the high cost of group home care, which can cost $8,000 per month or more (including board and care, mental health services, and education), the child may fall through the cracks and not be able to access group home services. At this point, families may start to disintegrate as they attempt to find resources for a child squeezed out by federal and state policies that provide access to services only through categorical funding streams. Parents sometimes abandon their child in order to gain access to care. Systems sometimes look for any technicality they can find to make a child a ward or dependent. The most logical solution to this problem would be to increase non-categorical funding for services to children and families and to loosen the categorical restrictions on the various funding streams.

WHAT ARE THE GOALS AND OBJECTIVES FOR THE SYSTEM OF CARE FOR CHILDREN AND YOUTH?

GOAL 1: Redefine the children's system of care.

OBJECTIVE 1: Expand the definition of the population to be served by the children's system of care to include all children and youth who receive services from the primary child-serving agencies, including children who are potentially eligible for those services.

OBJECTIVE 2: Ensure that a uniform, age-appropriate screening tool for assessing the needs of children and their families is developed and adopted by all child-serving agencies in the system of care.

GOAL 2: Advocate for more flexible, less categorical funding for the children's system of care.

OBJECTIVE 1: The State Legislature should appropriate a pool of non-categorical funds for each county system of care to be used flexibly by the child-serving agencies to meet the needs of children and their families.

OBJECTIVE 2: State agencies that oversee child-serving agencies in the counties should apply for waivers to federal agencies so that federal funds can be used to maximum benefit for children and their families.

OBJECTIVE 3: County government should establish a savings pool for funds that are saved by not placing children in high-cost, restrictive settings so that those funds can be redirected to meet the needs of children and their families.

GOAL 3: Advocate for creation of a state-level Children's Council and Children's Council of Statewide Associations

DRAFT

OBJECTIVE 1: The CMHPC should work with the California Institute for Mental Health (CIMH) and the California Mental Health Directors Association (CMHDA) to determine what steps have already been taken to implement this goal.

- In collaboration with CIMH and CMHDA, the CMHPC should initiate contact with the Administration to urge the creation of a state-level Children's Council.
- In collaboration with CIMH and CMHDA, the CMHPC should convene a meeting of statewide children's associations to plan for the creation of a Children's Council of Statewide Associations.

OBJECTIVE 2: These state-level groups will work to ensure that state regulations, required local advisory groups outcome measures, and paperwork requirements are consistent and not duplicative for the child-serving agencies in a county implementing state-mandated programs.

OBJECTIVE 3: The state-level groups will work with local agencies to eliminate duplicative data gathering for families being served by more than one local agency.

GOAL 4: Ensure that Interagency Policy Councils and Interagency Case Management Councils function effectively.

OBJECTIVE 1: The membership of the Interagency Policy Council should be expanded to include a parent of a minor child and a youth representative.

OBJECTIVE 2: The CMHPC should conduct a study of the existence and functioning of these councils. This study should include:

- whether membership matches statutory mandate;
- whether parents and youth are represented;
- whether the councils function as described in statute.

GOAL 5: Ensure that children, youth, and families are involved in all aspects of planning, delivering, and evaluating services.

OBJECTIVE 1: Involvement in service delivery.

A. Children, youth, and their families should be fully involved in all stages of service delivery: assessment, establishing goals, treatment planning, referrals for ancillary services, evaluation of progress, and transition planning for service termination.

B. Supervision of provider staff should emphasize child and family involvement at all stages of treatment.

C. Quality assurance reviews should emphasize child and parent involvement.

OBJECTIVE 2: Involvement in county system-of-care policy, planning, and evaluation.

A. Mental health boards and commissions should include parents of children who have been served by the public mental health system.

B. Mental health boards and commissions should include youth up to age 25 who have been in the public mental health system.

C. Parents and youth should be included in all county mental health policy, planning, and advisory groups for mental health, including management teams.

D. Parents and youth should be included on the boards of directors or advisory boards of all agencies that have contracts to provide county mental health services to children and youth.

OBJECTIVE 3: Hiring parent partners and youth advocates to provide peer support and advocacy to parents and youth receiving services.

A. Youth who have received mental health services should be hired as Youth Advocates/Peer Counselors by both county-operated programs and community agencies.

B. Parents of children who are now or have received mental health services should be hired as Family Advocates by both county-operated programs and community agencies.

DRAFT

OBJECTIVE 4: Ensure that youth and families are involved in all aspects of state mental health policy, planning, and evaluating services.

A. Youth up to the age of 25 who have been in the children's mental health system should be represented on all state committees and advisory groups, including the CMHPC.

GOAL 6: Advocate for expansion of infant mental health pilot programs.

OBJECTIVE 1: The CMHPC shall assist the DMH in disseminating information about the need for infant mental health programs.

OBJECTIVE 2: If the infant mental health pilot program currently implemented by the DMH produces positive outcomes for young children and their families, the CMHPC will urge the Legislature to appropriate funds for all counties to provide infant mental health programs.

GOAL 7: Expand mental health services for children with serious emotional disturbances in child care and after-school care by ensuring early identification, referral for assessment, and early intervention through training and consultation for care providers.

OBJECTIVE 1: Develop collaboration among the Departments of Education, Mental Health, Social Services, and Developmental Disabilities to address the behavioral and mental health needs of young children in child and after-school care and to provide training and resources for child care providers.

OBJECTIVE 2: Identify legislative and regulatory methods for developing and maintaining services within the county mental health service delivery system for young children, families, and child and after-school care providers.

OBJECTIVE 3: Develop sustainable, local infrastructures to facilitate training and provide supervision of county child care mental health consultants.

A. Establish a team of trained child and after-school care mental health consultants in each county with the capacity to provide support and direct services to the child care community

B. In collaboration with education and training institutions, develop a training-of-trainers model and curriculum for mental health professionals who wish to work as consultants to child and after-school care providers. This curriculum shall include the following topics:

   - child development;
   - early childhood mental health issues; and
   - how to provide consultation services within the context of child and after-school care.

C. Include the following topics in training for child and after-school care providers:

   - when to seek mental health consultation;
   - how to identify children who may need mental health services;
   - how to identify specific problematic behaviors;
   - how to communicate effectively with mental health professionals and parents; and
   - how to access mental health services for children and their families.

OBJECTIVE 4: Develop evaluation protocols for child and after-school care mental health and behavioral health consultation services in order to stimulate policy formation and program development.

OBJECTIVE 5: Develop procedures for billing child and after-school care mental health consultation services through Medi-Cal; Early Periodic Screening, Diagnosis and Treatment; and other funding streams, such as private insurance.

GOAL 8: Expand the availability of mental health services for youth in juvenile halls.

OBJECTIVE 1: The State should ensure greater coordination between the Board of Corrections, the California Youth Authority, and the DMH regarding oversight of juvenile halls and the provision of mental health services to youth in juvenile halls.

OBJECTIVE 2: The Legislature should increase appropriations for all funds that can be used for mental health services for youth in juvenile halls.

DRAFT

OBJECTIVE 3: The DMH should monitor the provision of mental health services to youth in juvenile halls to determine whether access to services is increasing.

GOAL 9: Increase the identification of substance abuse problems in children and youth.

OBJECTIVE 1: The State should adopt a screening tool to identify children and youth with substance abuse problems.

OBJECTIVE 2: The State should implement an extensive training program of staff in all child-serving agencies to enhance their ability to identify children and youth with substance abuse problems.

OBJECTIVE 3: The State must eliminate disincentives for children and youth to disclose their substance use problems. Child-serving agencies must be able to assure children and youth that their self-disclosure of substance use will remain confidential and will not result in negative consequences, such as arrest, incarceration, or revocation of probation.

GOAL 10: Develop a service system for transition-age youth in every county. The service system should have the following components:

1. **Transition-age specialist.** Every mental health provider, including the Adult and Child Access Teams, that serves youth age 14 to 25 should identify a minimum of one transition-age specialist who can be a resource on issues such as housing, income, vocational services, education, mentoring, and peer self help.
2. **A transition-age coordinator** should be hired to provide monitoring of mental health programs serving transition-age youth; oversight; coordination; and linkage between the child and adult systems, other partners, and the child and adult programs.
3. **Transition planning.** When a youth receiving mental health services reaches age 14, a transition plan should be developed and implemented to assist in the transition to the adult system.
4. C**oordination between systems of care for adults and children.** Children's service coordinators should review all open mental health cases as their clients turn 17. Any necessary linkage and referrals to the adult system of care, housing, vocational services, and other services should be identified and carried out in a timely manner.
5. **Interagency case conferencing** should be held on a regular basis to coordinate services for youth who are experiencing especially difficult challenges. Relevant partners should attend and coordinate necessary services to stabilize the youth.
6. **A specialized transition program** should be developed to provide services, including rehabilitation services and service coordination, for youth ages 18 to 25 who have significant mental health needs and are at risk of homelessness. The transition program should perform the following functions:

    - Refer youth to specialists in housing, vocational services, education, income maintenance, socialization skills, alcohol and other drug services, and coordinate these services as needed.
    - Provide system level coordination through case conferences.
    - Support the development of self-help groups.
    - Teach living skills, social skills, dating, and how to make and keep friends outside of institutional living by using directed experience in the community rather than a didactic approach and by discussing new experiences with the youth.

7. **Provide housing services.**

    - Establish a revolving fund for lending money for deposits and first and last months' rent.
    - Provide support to assist youth to maintain subsidized housing.
    - Crisis respite housing.
    - Short-term shelter beds.
    - Apartment clusters.

8. **Self-help Groups and Youth Centers.** Develop Youth Centers for all youth in the community to provide opportunities for socializing and recreation with a specific component of peer support for youth with mental health conditions.

9. **Education.** Assist clients to obtain their high school diploma or GED and to go as far as possible in higher education. Provide educational support in the form of tutoring, mentoring, and coordination with the education system.
10. **Vocational Services.** Develop partnerships with employment training agencies to provide job referrals, assistance with applications, and job coaching.
11. **Mentoring.** Recruit, train, and coordinate volunteer mentors.
12. **County-level coalition of stakeholders.** Establish a coalition of advocates and other stakeholders to monitor the adequacy of services for youth in transition to make recommendations to improve services.

DRAFT

APPENDIX

SERVICES AND PROGRAMS PROVIDED BY COUNTY MENTAL HEALTH DEPARTMENTS

The mental health dimension of a system of care must have all the basic components available to meet the needs of children and their families. These components include screening, assessment, developing a client plan, service coordination, a full array of service options, flexible support services for the family, staffing, and advocacy.

Screening

The mental health system of care must have a screening procedure to identify those children and youth that may need services. A Mental Health Screening Tool for use with children age 5-18 provides professionals a simple way to identify children who should be referred for a full mental health assessment.

For those children and youth that do not meet the criteria, the system should make appropriate referrals so the child or youth accesses support elsewhere in the community. Thus, the system should perform the following functions for all children and families seeking services.

- triage and crisis evaluation;
- consultation;
- information and referral;
- assistance in identifying appropriate services; and
- outreach to identify children and youth through connections with other service systems and the community.

Assessment

All services should be based upon a dynamic, comprehensive biopsychosocial client assessment, which results in a coordinated client service plan. A medical examination should be part of the assessment. The assessment must document that the client has a mental health diagnosis, has a functional impairment, and requires services.

The assessment shall ascertain psychiatric condition, the living arrangements, individual and family strengths and needs, functioning in school and in the community, social relationships, and physical condition. The needs and wishes of the child and family must also be considered. All previously gathered relevant and available information on a child or youth should be reviewed to minimize unnecessary or duplicative testing.

The assessment shall be completed within 30 days unless the child or youth is in an emergency situation, i.e., the child or youth is dangerous to self or others or is unable because of a mental disturbance to take advantage of food, clothing, and shelter. In these instances, services may be provided without a full-scale assessment or plan.

Client Plan

Service planning will be done with age-appropriate participation of the child or youth, the family, representatives of other agencies with which the child and family are involved, and individuals who the child or family invite, such as a youth or family advocate, friend, or support person.

Services are planned across three dimensions: setting, intensity, and variety. Service settings could include any appropriate place for delivering care, such as home, school, a foster home, shelter care, juvenile hall, or other community location. Service intensity relates to the frequency with which the service is provided and to its duration. Service variety refers to the treatment and supportive services available. In developing an individual treatment plan, all three dimensions must be addressed so that the plan meets the unique characteristics of the child and family.

Every child or youth in the system of care shall have a client assessment plan. It shall:

- be developed within 60 days of the assessment;
- partner with the client, family members, legal guardian, significant others, and representatives of other agencies providing services;
- contain the client's long-term goals;
- contain specific objectives linked to the client's strengths and functional impairment;
- identify specific services the client will receive and who will provide them;

- utilize the least restrictive, most appropriate mental health setting for the child or youth at every stage of service delivery;
- be reviewed and updated at least every six months based on the child or youth's changing needs and conditions;
- provide for evaluating the child or youth's progress toward achieving the plan's goals; and
- specify discharge readiness criteria, i.e., when services will no longer be necessary.

Service Coordination

A system of care needs a comprehensive system for service coordination to provide services in accordance with the changing needs of a child and family. Each local mental health program shall develop a comprehensive system to accomplish the following goals:

- always be the fixed point of responsibility for the child and family and be the interface with all service providers and agencies;
- partner with children and their families in planning for and deciding upon treatment options;
- assist families in obtaining necessary services for their children and themselves;
- assist the child and family to develop internal and external supports and to connect the child and family to natural resources in the community;
- if indicated, assist families in applying for public entitlements, such as food stamps, scholarships, rent subsidies, and Supplemental Security Income, and in learning to use them;
- provide support to the client during transitions between programs utilizing interagency agreements and flexible funding as required by the individualized service plan;
- keep the family and client fully informed;
- advocate for the client's needs by identifying gaps in the system and bringing them to the attention of both management and the Interagency Children's Policy Council; and
- protect and advocate for the rights of children and youth.

Service Options

Service options are an array from which needed services may be selected. Services not already available in the community should be created. Services can be provided alone or in combination with each other. Combining various modes of treatment with services of other agencies can often generate creative uses of traditional treatment approaches. Coordinated treatment plans developed in concert with other agencies serving the child and family can enlist the aid of non-mental health professionals, such as special education teachers, probation officers, foster parents, or social service workers. Such concerted efforts by all the providers in a child's life increase the probability of positive treatment outcomes.

The array of services includes the following:

- individual and group therapy;
- family therapy;
- medication and medication monitoring;
- day treatment;
- crisis intervention available 24 hours per day, seven days per week;
- secure community treatment facilities;
- acute hospital care;
- intensive in-home services;
- rehabilitative services;
- respite services for families; and
- other services as identified by the child, family, and treatment team that will meet the individual and unique needs of the child and family.

Staffing

Staffing standards should be based on the number of children and youth served and the children and youth's acuity levels. Each local program should develop such standards, and treatment providers should adhere to them. All treatment programs must provide and document a specific plan of supervision for children and youth being treated covering all hours that children and youth are present. Staffing patterns at all levels should reflect,

to the maximum extent feasible, the cultural, linguistic, ethnic, and other social characteristics of the community. In addition to mental health professionals, staffing should also include peer providers, such as family advocates and youth advocates. Paraprofessionals should be enlisted to provide additional resources to assist in attaining goals.

Advocacy

Each local program must have a patients' rights office to ensure that the rights of children and youth and their families are protected, to bring deficiencies to the attention of the local mental health director, and to take remedial action. The patients' rights office shall have 1) access to children and youth and their records; 2) access to mental health providers; 3) authorization to invoke penalties for noncompliance with rights; and 4) an established grievance procedure for children and youth and their families.

CHAPTER 5

THE PLANNED SYSTEM OF CARE FOR ADULTS

WHAT ARE THE MISSION AND VALUES FOR THE SYSTEM OF CARE FOR ADULTS?

The mental health constituency envisions a society in which adults with mental disabilities and their families can develop the skills and acquire the supports and resources they need to succeed where they choose to live, learn and work; and to be responsible members of the community. This vision is best achieved through the development of a community-based system of care that treats adults with mental disabilities with dignity and respect and empowers them to take an active role in their recovery. The purpose of creating a public mental health system that promotes wellness is to accomplish the following goals:

- to be healthy;
- to live where they choose;
- to engage in school, work, and other satisfying and productive daily activities;
- to have adequate income;
- to be safe and abide by the law; and
- to have supportive relationships with others and meaningful connections to their communities.

The development of the community mental health system began with deinstitutionalization in the 1960's. The mental health system was faced with the fact that people with mental illness have residential, vocational, educational, and social needs and wants. In the 1970's, the community support system was developed to identify the essential components needed by a community to provide adequate services and support to persons with mental illnesses (National Institute of Mental Health, 1987, page 12). The community support system was defined as "a network of caring and responsible people committed to assisting a vulnerable population meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community" (Turner,). In the 1980's, the concept of psychiatric rehabilitation began to emerge. The rehabilitation model emphasized that mental illness not only causes mental impairments but also causes the person significant functional limitations. The rehabilitation model emphasized treating both the illness and its social consequences.

Recovery

California's mental health system is promoting recovery as a fundamental value for its adult system of care. Although the phrase "recovery" is being used widely in discussions regarding the delivery of mental health services, many clients, family members, and providers are concerned about this term. Some clients may feel pressured by this philosophy or they may believe that they are not measuring up. Or, if they do respond and then, get better, they may think that the system will consider them "recovered" and no longer in need of services. Providers need to understand and to emphasize to clients that each individual is unique and achieves different levels of recovery.

Recovery emphasizes a shift from a provider-based system of care to a system that values a network of support that is both provider-based and consumer-directed. Providers engage consumers to actively create and manage their own individual treatment plan rather than treating them as passive, dependent recipients of care. William Anthony, one of the first and foremost authors to write about recovery for persons with mental illness, provides the following description of recovery:

> Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. (Anthony, 1993).

Mary Ellen Copeland, a recovering client and national leader in the recovery movement, emphasizes the importance of hope in recovery:

> We don't need dire predictions about the course of our symptoms – something that no one else, regardless of their credentials, can ever know. We need assistance, encouragement, and support as we work to relieve the symptoms and get on with our lives. We need a caring environment without feeling the need to be taken care of (Mead, 2000).

All participants in a consumer's recovery process work together with the understanding that recovery is always possible. For some individuals, recovery may be a longer, more gradual process. In order to support recovery, services must be continuously available and accessible as each individual's recovery indicates. Because each individual defines recovery differently, recovery occurs at different degrees for each consumer. In addition, for many consumers, spirituality is a significant aspect of recovery and may be a critical element of well being.

The concept and experience of recovery may also be different for clients with different ethnic backgrounds. The mental health system must explore how a recovery vision can reflect the experience and values of the diverse ethnic groups in the State. In fact, the California Mental Health Directors Association makes the following statement in its Adult System of Care Framework:

> The cultural identities and worldviews of the consumers shape health and healing beliefs, practices, behaviors and expectations. Wellness is therefore, uniquely defined by each individual and each cultural group (California Mental Health Directors Association, 2000).

Current Treatment Models

The mental health system needs a comprehensive array of services in order to provide a system of care for adults, including the development of community residential treatment systems that provide alternatives to hospital and institutional care and are designed to help "deinstitutionalize" service delivery systems while they provide a community-based rehabilitation and recovery-oriented setting to address consumer needs.

Clients should participate in developing their individualized treatment plans with a coordinator or a team of individuals. These services must include the use of culturally appropriate needs assessment tools, relevant performance indicators, alternative service delivery models, neighborhood support systems, cross-cultural training for staff, and racially, ethnically, and culturally diverse staff able to speak the language of the client. Appendix I at the end of this chapter describes services that are necessary to provide a full continuium of care so that each client can have access to those services necessary to facilitate his or her recovery.

Current trends in mental health service delivery include adult system-of-care models, such as assertive community treatment (ACT) and the integrated services agency (ISA). ACT and ISA models embrace the strategy of continuous community support services that facilitate a stable and satisfactory life and reduce the frequency, duration, and severity of relapse. In ACT and ISA models, all services to individuals are coordinated through an individual or team that functions as the single point of responsibility for all needs, helping individuals remain stable, increase functional capacity, and achieve a decent quality of life. These models should incorporate recovery concepts into their core values and programs. This blending of approaches, which requires a shift in the perspective of providers, professionals, clients, and family members, is already starting to occur. In fact, the California Mental Health Directors Association, working with representatives of the mental health constituency, is currently developing an adult system-of-care framework that embraces recovery-oriented services.

Concerns have been raised that in many counties, staff are not trained to provide recovery-oriented services, including developing treatment plans with a recovery orientation. Many clients may lack access to or be denied ongoing support services that will help them to make progress toward their recovery.

Recommendation: The Department of Mental Health should develop training and resouurce materials to train county mental health staff on how to develop and document rehabilitation and recovery-oriented services. The Department should complete a study to determine the extent to which persons who meet the target population are denied services and the extent to which Medi-Cal recipients are being denied access to ongoing support services.

Recommendation: County mental health staff, provider organizations, consumers, and family members should be trained in the values and principles of recovery and should actively support recovery processes and the development of mental health services that enhance each consumer's recovery.

Recommendation: Consumer response to the Mental Health Statistics Improvement Project Consumer Survey, one of the outcome instruments for the adult system of care, should be monitored to assess the recovery orientation of mental health services.

WHAT ARE THE PRIORITY TARGET POPULATIONS IN THE SYSTEM OF CARE FOR ADULTS?

Statutory Definition

The impetus to develop California's adult target population definition began as a result of limited resources in the 1970's and 80's. County mental health departments had only a fixed amount of resources to provide to persons with mental illnesses. In most cases, this fixed amount was not sufficient to provide services to everyone that needed them. Counties were forced to prioritize service delivery so that only those clients whose symptoms were most severe were treated.

With the passage of the realignment legislation in 1991, the adult target population definition was put in statute. Welfare and Institutions Code (WIC) Section 5600.3 describes the target population for adults with mental illness who are served by the public mental health system. That definition states that a client's mental illness must be severe in degree and persistent in duration, may cause behavioral functioning that interferes substantially with the primary activities of daily living, and may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time.

Medi-Cal Managed Care Medical Necessity Definition for Recipients of Specialty Mental Health Services

With the consolidation of fee-for-service Medi-Cal mental health services and public Short-Doyle Medi-Cal mental health services, a "medical necessity definition" was developed to apply to both groups of Medi-Cal beneficiaries who now receive mental health services through the public mental health system.

Medical Necessity for Inpatient Mental Health Services

Section 1820.205 of the regulations governing the Medi-Cal inpatient mental health services defines medical necessity for inpatient services. A beneficiary must have a specified diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM IV) and require psychiatric inpatient hospital services as the result of a mental disorder, due to certain symptoms or behaviors.

Medical Necessity for Outpatient Mental Health Services

Section 1830.205 defines medical necessity for outpatient, or "specialty" mental health services. Beneficiaries must have a DSM IV diagnosis with a significant impairment related to the diagnosis or the probability of significant deterioration or lack of developmental prog??ress. Eligible care for medically necessary services must be focused on the impairment; the client must be expected to benefit from the intervention; and the conditions should not be responsive to treatment that could be provided by the physical health care system.

Although a single standard of care in which only one target population definition is used would be most logical for persons who need mental health services, a lack of resources causes this dual system of care. Many clients are not eligible for Medi-Cal benefits. For these clients, counties must still prioritize services based on whether these clients meet the target population definition because the county must pay for services provided to these clients through limited public mental health dollars that are allocated from realignment funding.

Recommendation: The State should maximize mental health coverage to all adults with serious mental illnesses so that universal mental health parity will include a comprehensive array of services, including rehabilitation and recovery-oriented services.

WHAT SERVICES AND PROGRAMS SHOULD BE PROVIDED TO ADULTS WITH MENTAL DISABILITIES TO IMPROVE THEIR OUTCOMES?

Accountability in California's mental health system is accomplished in part through the use of performance outcome data. Chapter 7, System Accountability and Oversight, provides a detailed summary of how this system of accountability evolved and how the California Mental Health Planning Council (CMHPC) intends to use performance indicators for system oversight. Performance outcome indicators are intended to quantify for each county measurable changes in clients' lives to determine if mental health services are improving basic aspects of clients' quality of life.

DRAFT

Problem: Clients often cannot get timely access to mental health services.

Access to mental health services is obviously a prerequisite for achieving positive outcomes for clients. Chapter 2 indicates that an overwhelming number of adults in need of public mental health services do not have access to them. At best, lack of access means that clients do not improve and may become more ill. At the other end of the spectrum, however, one of the worst possible outcomes as a result of lack of access is the increased risk of clients committing suicide. The Suicide Prevention Advocacy Network (SPAN) of California states that of the 30,000 suicides that occur each year, most of them result from depression or other form of mental illness. In fact, SPAN reports that 90 percent of persons who commit suicide have a mental disorder or substance abuse disorder. Although being suicidal is one of the criteria that requires that a person be hospitalized for evaluation under the civil commitment law, the mental health system is limited by its lack of resources and services in the community.

Over the last few years, the Legislature has provided specific categorical augmentations that have improved access for some clients. However, the mental health system really needs both a substantial general augmentation to its funding, and development of meaningful access measures, so that timely access to effective services is available for all clients who seek mental health services.

Recommendation: The Administration and the Legislature should appropriate additional funds for services for adults.

The following sections of this chapter are divided into six aspects of a client's life, which include health, living situation, productive daily activity, financial status, legal issues, and social support network. Each section describes problems and challenges clients face achieving positive outcomes in these domains, reviews proposals and pilot projects to address these problems, and makes recommendations for system change.

Health

Physical Healthcare

Problem: Clients' physical health problems often go undetected, untreated, or inappropriately diagnosed.

Many studies have shown a very high prevalence of serious physical illnesses in persons being treated for mental illness. These physical illnesses are often undetected or untreated because the client cannot effectively communicate the physical symptoms and physicians often attribute somatic symptoms to the mental illness. Kaplan states that anywhere from 24 to 60 percent of persons who have been identified in the target population have been shown to suffer from associated physical disorders (Kaplan, 1998, page 299). In 1985, in response to Chapter 208, Statutes of 1982 (SB 929), Koran studied the prevalence of undiagnosed and untreated physical diseases in clients under the care of county mental health systems in four California counties (Koran, 1985). The study revealed that 45 percent of the clients had acute physical diseases. Twenty-two percent had their disease detected at the time of intake into the mental health system, and 23 percent of the clients had diseases that remained undiagnosed.

Kaplan (1998) states, "Among the most inappropriately treated patients in the mental health system are those who have medical problems that either cause or contribute to their psychiatric symptoms. Study after study has shown that psychiatric patients have more medical problems than the average members of society and that the most severely psychotic in this population have the most serious and/or the greatest numbers of medical problems" (Kaplan, 1998, page 152).

With the advent of managed mental health care in the public sector, California's mental health system "carved out" its services into "specialty mental health" services, designed to serve Medi-Cal beneficiaries whose mental illnesses meet the medical necessity definition criteria. (See Chapter 6, Managed Mental Health Care, for more information on this system.) The county managed health care plans, which are responsible for providing physical health care to Medi-Cal recipients, and the county managed mental health plans have developed memoranda of understanding to coordinate care. This coordination includes providing clinical consultation and training, referral protocols, exchange of medical records information, and a process for resolving disputes between plans.

Egnew and Geary, describing the interface with health care in a carved-out mental health care system, report that the challenges include ensuring a timely process for referral, information sharing, and consultation and

ensuring easy and timely access. They believe that "ensuring adequate access to both medical/surgical and behavioral healthcare is a critical public policy issue" (Egnew, 1996).

Primary care providers actually see a large percentage of clients with significant psychiatric diagnoses. The California Medical Association (CMA) estimates that about eighty percent of persons with mental illness are seen first by primary care physicians (California Medical Association,). Primary care physicians should be able to identify these illnesses accurately and make the appropriate diagnosis or refer clients to specialty mental health services. If mental illnesses are identified and treated in a timely manner, client outcomes are better and treatment is more cost-effective. In 1998, the California Medical Association adopted a resolution to collaborate with other organizations to provide mental health training for primary care physicians. (California Medical Association, 1998). Although the problem has been addressed, it has not been solved.

Although women utilize health services more than men do, they still face significant barriers, including lack of or inadequate health insurance coverage. Services to meet the needs of women who face trauma, severe depression, eating disorders, or other psychological disabilities are insufficient (California Institute for Mental Health, 1999).

Recommendation: Mental health clinicians should ensure that clients entering the mental health system receive thorough physical exams.

Recommendation: Mental health providers should encourage clients to use health care, especially education and prevention services, such as smoking cessation programs.

Co-Occurring Mental Illness and Drug and Alcohol Use

The Department of Mental Health (DMH) describes the problem of co-occurring mental health and alcohol and drug use as follows:

> Within the last decade it has become increasingly clear that substance abuse and mental illness when occurring simultaneously present a synergistic force which exacerbates both problems. Persons with a co-existing disorder are among the highest cost users within the publicly funded health care and criminal justice systems, and are a public safety concern when left untreated…(California Department of Mental Health, 1997b).
>
> It is estimated that approximately 60 percent of persons with Serious Mental Illness (SMI) also have a substance abuse problem and that up to 90 percent or more of the highest cost users of services and forensics consumers also abuse substances (California Department of Mental Health, 1997a, page 16).

The Program for Assertive Community Treatment (PACT) Model describes the challenges faced by clients with co-occurring mental illness and alcohol and drug use:

> Clients with dual diagnosis present a substantial treatment challenge to mental health systems. As compared with other clients, their functioning is poorer (e.g., increased symptoms and impairment, hospitalization, incarceration, homelessness, physical problems), and they are more difficult to treat and rehabilitate (e.g., less adherent with mental health and substance abuse treatment services, showing a greater complexity of problems and needs). (Allness, 1998, page 58).

Problem: Lack of integrated treatment programs for co-occurring mental health and alcohol and drug use.

Historically, treatment of mental illness and substance abuse has been addressed by separate programs typically under separate government departments or agencies. Basic treatment philosophies between the two systems differ substantially. Many substance abuse treatment programs require total abstinence from any substance, which poses a problem for mental health clients with substance abuse problems who must take medications to control their mental illnesses. The DMH states that, "It is imperative that attempts to address issues of dual diagnosis take place as an integrated and unified program. Integrated service delivery for both problems has been shown to be highly cost-effective" (California Department of Mental Health, 1997b).

In May 1995, the Department of Mental Health (DMH) and State Alcohol and Drug Programs (ADP) formed the Dual Diagnosis Task Force. The purpose of the Task Force is to support the development of and promote effective programs for clients with dual diagnosis, to foster cooperative efforts in the treatment of this group of clients at the local level, and to promote access to those treatment programs. The DMH and ADP awarded three

million dollars over a three-year period in federal Substance Abuse and Mental Health Services Administration (SAMHSA) funds to four projects. Each project is designed to demonstrate the efficacy of integrated mental health and alcohol and other drug treatment/recovery programs for persons with a dual diagnosis in a county system of care. Following the conclusion of the projects in 2000, they will be independently evaluated to provide data on the effectiveness of integrated treatment, clinical outcomes, consumer satisfaction, client quality of life, costs, and cost savings or avoidance in the area of physical health care and criminal justice.

Recommendation: If the dual diagnosis pilot projects prove to be effective, the DMH and ADP should seek funding to expand integrated treatment programs for clients with dual diagnosis by offering incentives or matching funds to counties that replicate these models.

Recommendation: The DMH and ADP should aggressively promote the funding of such services including changes to the federal SAMHSA Block Grant.

Living Situation

Problem: Housing shortages and homelessness.

The DMH reports that approximately "seven percent of the adult population in the United States, or about 12 million Americans, have been homeless at least once in their lives. More than three-quarters of homeless single adults have persistent mental or physical illnesses or substance abuse problems. In California, at least 150,000 people are homeless, and studies indicate that at least half are disabled with mental illness, medical problems, or other health conditions" (California Department of Mental Health, 1998a).

A report prepared by the State Independent Living Council in April 1999 states that "Housing affordability is a major problem in California…There is a severe scarcity of low-income housing in communities throughout California, notably in major metropolitan areas. Individuals who rely exclusively on Supplemental Security Income (SSI) cannot pay the prevailing or market rental rate for any type of decent apartment or house…Given the lack of low-income, accessible housing, increasing numbers of people with disabilities are forced to choose between restrictive congregate settings and homelessness" (Tootelian, 1999). In California, Supplemental Security Income/State Supplemental Program (SSI/SSP) is only $692.00 per month for most clients. This amount is insufficient in many counties. In fact, at the June 2000 CMHPC meeting, a client recently testified that in San Mateo County clients are living with four or more clients in a small two-bedroom apartment and giving up half or more of their SSI/SSP check for rent. The rest of the money goes to buy the food and other necessities they will need for the month.

Persons with mental illnesses face multiple barriers to finding and maintaining safe, affordable housing. Besides lacking adequate income, many people have co-occurring disorders, including alcohol and other drug problems and acute or chronic physical health problems. They also face stigma associated with their illnesses and the fears of potential landlords or neighbors. Women who are homeless and mentally ill face additional gender/role barriers. They are more vulnerable to sexual trauma and violence. Some women are reluctant to access housing services for fear that their children may be taken away from them. Often, housing programs have rigid guidelines for women using the facilities. Women may not be able to comply with the rules if they have children in their care or other problems.

Persons with mental illnesses need the support of community mental health services to be able to maintain housing in the community. They also need access to a full continuum of housing, from crisis residential facilities through permanent supportive housing. The community residential treatment system, which was established in the 1980's, provides for a complete array of housing to meet the level of need of each client. The common thread among these programs is individualized focus on consumer needs and a rehabilitation and recovery-oriented philosophy. Some advocates, however, believe that although persons with mental illnesses have varying needs for support at different times in their illnesses, their housing does not necessarily have to change as those needs change. They believe that forcing an individual to move just when he or she has achieved some level of comfort and competence in a particular living situation may be detrimental and that housing arrangements should be permanent with flexible supports provided onsite or offsite for as long as the individual needs or desires them.

Regardless of what stakeholders believe is the best housing philosophy for mental health clients, the overall problem is lack of housing at all levels, which contributes to homelessness and inappropriate institutionalization. In some counties, housing is non-existent and clients must be sent to facilities in other

counties to live. Many acute care hospitals must keep clients in an acute care setting for lack of placement in the community. This issue is becoming increasingly more critical. To make matters worse, California is experiencing a decline in board and care residences. Although board and care residences are viewed by many advocates as less than ideal housing for mental health clients, in many cases, these residences have been the only affordable and available housing option. The amount of the board and care rate under SSI is so inadequate that many board and care operators are evicting persons with mental illnesses who only receive SSI in order to provide services to persons who receive a county rate augmentation or "patch." Others are asking family members to pay the difference between SSI rates and market rates. Many providers are going out of business altogether and many of the board and care residences that continue operate substandard programs that do not even meet minimum licensing requirements.

Although many clients want to live independently, some clients may have different goals due to cultural and ethnic differences. The mental health system needs to take into account how such differences might influence a client's preferred living arrangement. Housing should be culturally congruent. Independent housing may not be the ultimate goal of clients from different cultural backgrounds. For example, in some Asian cultures, young women are expected to live with their families until they get married. In some Latino families, reunification with the family may be the goal.

Recommendation: The State should provide more resources to mental health programs to provide for a full continuum of housing to mental health clients.

Federal and State Efforts to Provide Housing

The DMH has received federal homeless funds through the Stewart B. McKinney Homeless Block Grant since 1985. Beginning in 1991, the funding came through the McKinney Projects for Assistance in Transition from Homelessness (PATH) formula grant. Each county with PATH programs has established one or more programs of outreach or services to persons who are homeless and have a mental illness.

In State Fiscal Year 1998-1999, the DMH assumed an active role in the development of supportive housing for persons with a serious mental illness who are homeless or at risk of homelessness. The DMH redirected increases from the PATH and Substance Abuse and Mental Health Services Administration (SAMHSA) programs to initiate a competitive grant process that resulted in mental health funding of 13 supportive housing demonstration projects in both rural and urban counties.

Additionally, pursuant to the California Supportive Housing Initiative Act (SHIA, Chapter 310, Statutes of 1998) the DMH became the lead agency in administering supportive housing grants for low income persons with serious mental illness and/or other special needs populations. This legislation also established the Supportive Housing Program Council, which is comprised of representatives from multiple state agencies, consumers, and family members who provide recommendations and support to the DMH in administering this grant program. Under the SHIA program, six supportive housing projects were funded in SFY1999-2000 and five have been funded this year. The Budget Act for Fiscal Year 2000-2001 have provided an additional $25 million for additional new projects.

Recommendation: The DMH should continue its efforts in the statewide expansion and development of new supportive housing grants through both state and federal funding.

Recommendation: The DMH should encourage housing programs to reduce restrictions that present barriers to women with mental illness, including women with children. Programs should engage in outreach to women with mental illness, offer community support tailored to their needs as caregivers, and be flexible in their requirements so that they do not preclude serving women with children.

Olmstead v. L.C.

The United States Supreme Court held in the case of Olmstead v. L.C. (need to get cite) that the Americans With Disabilities Act (ADA) requires that services be provided in the most integrated setting appropriate. California is obligated under the Olmstead decision to develop an effective working plan for transitioning individuals who can benefit from community services out of institutions and into the community. The DMH is deferring the Olmstead planning to the California Long-Term Care Council, which is developing structural changes to California's administration and delivery of long-term care services. However, the Olmstead decision goes beyond this and requires that individuals who could benefit from community placement be identified and

assessed for need of community services. These services must be made available in a reasonable period of time so that these individuals can transition to the community.

Many individuals who could benefit from community services remain institutionalized. As the number of civilly committed residents in state hospitals declines, the number of residents in institutions for mental diseases (IMD) is increasing. IMDs, which are primarily locked nursing facilities, have become a substitute form of institutionalization.

The State and the counties have an obligation under the Olmstead decision to reduce the use of IMDs. In addition, they have a strong financial incentive to do this as well because counties cannot be reimbursed for federal financial participation for those residents in IMDs and must fund these placements with 100 percent county dollars. Clearly, IMDs are not cost-effective but the lack of a full array of housing for mental health clients in California is one of the problems that counties face in trying to place many clients in less restrictive care.

Recommendation: The Department of Mental Health and county mental health departments should work together to actively develop and implement effective working plans based on the Olmstead decision.

Recommendation: The Department of Mental Health should prepare a report with current data on IMDs, including their locations, populations, costs, average length of stay, residents' county of origin and other relevant data. The report should made recommendations regarding options to reduce reliance on these facilities as a means to promote community integration and more cost-effective care.

Productive Daily Activity

Productive daily activity includes engaging in meaningful daily activities, including education and training, volunteer activity, and competitive employment.

Education Supports and Reasonable Educational Accommodations

New opportunities to obtain a college education have opened up for mental health as Jackie Groshart, Psychological Disabilities Specialist, explains:

> Individuals with major mental illness often experience their first symptoms at the age when they would typically be entering college. In the past, depending on the severity of the symptoms, they have either been unable to pursue their education or have been severely limited in this area. Today with the advent of extremely effective medication and adjunct therapy to control symptoms, and the passage of legislation which ensures the right to accommodations, an increasing number of these students are able to attend school successfully (Groshart, 1997).

Educational accommodations and auxiliary aids that help to level the playing field for persons with disabilities in higher education must also be provided to qualified students with psychiatric disabilities. In addition to mandated accommodations, postsecondary education institutions provide varying degrees of educational support services depending on the segment, the individual campus, and whether funding is private or public.

Reasonable accommodations and support services encourage individuals with mental disabilities to enter or reenter adult, postsecondary, and technical education institutions. Examples of reasonable accommodations include assistance with registration; testing accommodations (extended time or taking tests alone with a proctor) to alleviate difficulty during timed tests; tape recorders in class to remedy easy distractibility; note takers to compensate for poor concentration; access to special parking; and seating arrangement modifications. Examples of supports include access to campus counselors trained in psychiatric disabilities, peer supports, advocacy skills training, access to special classes such as stress management and memory enhancement, assistance accessing campus services and resources such as financial aid, and assistance with retention-related problems while hospitalized.

Access to reasonable accommodations and related services for students with mental disabilities can help them be successful in higher education. Campus counselors must have a combination of counseling skills, a supportive and nonjudgmental attitude, and the knowledge of disability issues (Groshart, 1997) but do not necessarily need to be specialists in psychiatric disabilities (Parten, in press). Some postsecondary institutions provide specialized counselors for students with mental disabilities; a few community colleges offer specialized programs. However, 2- and 4-year college counselors for students with disabilities are, for the most part, generalists, while adult education entities may be unaware of the needs of this population. Adult and higher

education entities that have access to a wide range of counselors, services, and relevant curricula are able to successfully accommodate, serve, and support a wider range of students with mental disabilities (Parten, in press).

Recommendation: County mental health departments should train staff in education accommodations and documentation of a disability-related educational limitation; initiate education supports in collaboration with adult, technical, and postsecondary education entities; and expand existing on-campus and off-campus supported education programs.

Recommendation: Clients' interest in pursuing adult or postsecondary education or technical training should be assessed. Clients should be informed of their legal right to accommodations in higher education settings and of the specific accommodations, services, supports, and resources available. Clients should also be informed that postsecondary education institutions are not required to provide services beyond academic accommodations; individual campuses may choose to provide enhanced services, but are not required to do so.

Recommendation: County mental health departments should advocate for more funding, training, and education of adult and postsecondary education counselors who are specifically assigned to students with mental disabilities.

Employment

The Report of the Surgeon General states that people with severe mental illnesses tend to be poor (U.S. Department of Health and Human Services, 1999). Although the reasons are not understood, poverty is a risk factor for some mental disorders as well as a predictor of poor long-term outcome among people already diagnosed. People with serious mental illnesses often become dependent on public assistance shortly after their initial hospitalization. The unemployment rate among adults with serious mental disabilities is approximately 90 percent. Women with mental disabilities have a lower employment rate than men with mental disabilities and appear to underserved by rehabilitation services. Only 40 percent of people with mental illness who receive rehabilitation services are women (California Institute for Mental Health, 1999).

Problem: Lack of employment that provides flexibility for persons with mental illness.

The Surgeon General's Report also observes that an adequate standard of living and employment are associated with better clinical outcomes and quality of life. Although newer vocational rehabilitation and employment initiatives strive to remedy persistently high levels of unemployment, most consumers find themselves unable to work consistently or at all. This problem results from active symptoms, profound interruptions of education and employment caused by symptom onset and exacerbation, stigma and discrimination, lack of higher education programs, and being limited to low-paying menial jobs.

According to the National Association of State Mental Health Program Directors (NASMHPD),

> The lack of jobs that provide flexibility for adults with serious mental illness is a major barrier to successful community living, a personal loss to people who wish to work, a societal loss to employers and taxpayers, and a barrier to successful recovery for those with mental illness.
>
> Chronic unemployment can lead to isolation, poverty, and a diminishing self-worth in any adult, hindering efforts at recovery. In addition, one residual effect of chronic unemployment for persons with psychiatric disabilities is the perpetuation of homelessness. The current high rate of unemployment among people with psychiatric disabilities – estimated at 85 percent – must be lowered. The focus should not only be on employment opportunities, but also on habilitation and rehabilitation, including integrated supported competitive employment to better enable individuals with mental illness to participate in the workforce (National Association of State Mental Health Program Directors, 2000).

Employment that is competitive, integrated, paid, and meaningful is of fundamental importance to the quality of life for persons with mental disabilities. The NASMHPD position statement on employment and rehabilitation makes the following points:

- State mental health authorities should assume a leadership role in significantly increasing the rate of employment among individuals with psychiatric disabilities.

- Vocational rehabilitation agencies and state mental health authorities should collaborate and design program linkages and develop a range of employment options to increase rehabilitation opportunities to individuals requiring mental health services.
- Mental health policymakers should work to maximize the availability of community supports and case management efforts that focus on employment issues early in the rehabilitation process.
- Employment support and rehabilitation standards must be flexible to accommodate the episodic nature of mental illnesses.
- Effective rehabilitation services must view successful rehabilitation for individuals with mental illness differently than for others, adapting to the needs of all individuals with psychiatric disabilities.
- Employment support must be an integral component of comprehensive community support programs (National Association of State Mental Health Program Directors, 2000).

Recommendation: County mental health departments should initiate new supported employment programs and expand existing programs for persons with mental disabilities.

Department of Mental Health/Department of Rehabilitation Cooperative Programs

County mental health departments and the California Department of Rehabilitation (DR) have joined together to provide an array of cooperative services throughout the State. These programs have been built with consumer and family member participation. They embrace the values of comprehensive service linkages; consumer career choice; placement in a competitive, integrated environment; reasonable accommodations; and ongoing support. Currently, 27 cooperative agreements exist. In addition, the DMH and the DR have an interagency agreement to provide coordinated vocational services for clients as they transition from state hospitals to local communities. Mental health professionals involved in these cooperatives continue to work with rehabilitation counselors through continuing education to identify the unique needs of persons with psychiatric disabilities.

Recommendation: The DMH/DR Cooperative model should be encouraged in every county in California.

Recommendation: The DMH and DR should continue to provide staff with cross training about the needs of persons with mental disabilities.

Financial Status

Problem: Public assistance is not enough for clients to be able to afford anything other than the bare essentials.

Persons with mental illness should have an adequate income. According to the Department of Health and Human Services, "people with serious mental illnesses often become dependent on public assistance shortly after their initial hospitalization. The unemployment rate among adults with serious mental disorders hovers at 90 percent. Consequently, they must rely on government disability-income programs, rent subsidies, and informal sources of economic support. Clients usually face such modest monthly budgets that there is no room for error. Funds are frequently depleted before the end of the month. (U.S. Department of Health and Human Services, 1999).

Recommendation: The CMHPC should facilitate a coordinated advocacy campaign at both the federal and state level to increase income supports for persons with mental illness.

Problem: People have a disincentive or are afraid to work because they could lose their SSI/SSP or other benefits, such as Medi-Cal.

Being able to work does not preclude the need for long-term services and supports, such as counseling and medication. "Those who work part time, and even many with full-time jobs, may not be able to obtain adequate insurance through their employers to cover their ongoing medical needs. In addition, because of the long-term and fluctuating nature of some mental illnesses, people with psychiatric disabilities may continue to go through periods when they are unable to work, thus requiring the continuation of medical and other benefits" (U.S. Department of Health and Human Services, 1999).

The National Council on Disability points out that a significant barrier to work is the possibility of losing benefits. "Many people with mental disabilities fear that if they work, the Social Security Administration (SSA) will declare them no longer disabled and therefore ineligible for further benefits, even though they have had no

medical improvement. Because the probability of a recurrence is high, they are afraid to take the risk" (National Council on Disability, 1997)

The National Alliance for the Mentally Ill (NAMI) has advocated at the federal level for flexibility in the Medicaid law to allow people with mental illness to remain working while accessing health benefits:

> People with severe mental illnesses and other disabilities should not be forced into (and stay in) poverty in order to access Medicare or Medicaid. At the same time, these programs need to remain in place as federal entitlements in order to ensure that persons whose symptoms or impairments are so severe that they cannot work are not at risk for losing cash benefits or health coverage (National Alliance for the Mentally Ill, 2000).

In 1999 the "Ticket to Work and Work Incentives Improvement Act" (PL 106-170) made improvements in disability programs, allowing social security disability income (SSDI) and supplemental security income (SSI) beneficiaries to work to the greatest extent of their abilities. This Act shifted the philosophy behind the nation's public disability programs, including SSI, SSDI, Medicaid, and Medicare, to programs that foster work, independence, and self-sufficiency for people with mental illnesses.

PL 106-170 allows States to offer Medicaid coverage to SSI beneficiaries who go to work and allows a Medicaid buy-in for people with disabilities who earn more than 250 percent of the poverty level. California enacted Chapter 820, Statutes of 1999, which implemented this provision. Any employed person whose income does not exceed 250 percent of the federal poverty level and who is disabled for specified purposes is eligible for Medi-Cal benefits, subject to a sliding scale.

Recommendation: Providers, clients, and families should be educated about the reporting requirements if a client returns to work while in receipt of SSI or SSDI and the provisions that may be available to extend a client's benefits upon return to work or to reinstate benefits should the client be unable to continue working.

Legal Issues

Problem: Increased numbers of persons with mental illness who are involved with the criminal justice system.

Factors contributing to the increase in persons with mental illness who are involved with the criminal justice system can be traced back to the deinstitutionalization process of the 1960's as Izumi, Schiller, and Hayward explain:

> The expectation was that those persons not treated in the state hospitals would instead be treated in community settings. Unfortunately, reality did not live up to the plans of advocates and policymakers, and the mentally ill who previously would have been sent to state hospitals were instead often asked to fend for themselves, either on the streets or in the nominal care of relatives. Placed in this situation, the poor judgement, lack of control, and deteriorating living conditions of the mentally ill resulted, not surprisingly, in increased arrest rates... (Izumi, 1996).

Now 30 years later, community mental health resources are still inadequate. The mental health system is so overburdened that only those persons with the most serious mental illnesses are served. Chapter 2, Unmet Need for Public Mental Health Services, indicates that public mental health only serves approximately half of the total population in need of services. In many cases, the system does not have enough resources to use for anything other than acute hospitalization, which is the most costly, high-end intervention.

In 1993, the Los Angeles Board of Supervisors established a Task Force on the Incarcerated Mentally Ill. The Task Force studied the increasingly high rate of incarceration of persons with severe mental illness and provided recommendations. The Task Force stated:

> …it is clear that decreasing mental health resources and community support systems, increasing involvement of law enforcement officers with persons diagnosed with mental illness, insufficient intradepartmental and interagency collaboration, and very importantly, societal conditions disproportionately affecting persons with mental illness have resulted, at times, in the unnecessary criminalization of the target populations (Los Angeles County Task Force on the Incarcerated Mentally Ill, 1993, page 18).

Chapter 617, Statutes of 1999 (AB 34) was enacted to provide outreach to adults with mental illness who are at risk of being homeless, who are homeless, or who frequently enter the criminal justice system. The goal of

these programs is for communities to provide outreach, mental health care, and follow-up services for the homeless, including housing and employment assistance. Initially, funding was provided to three demonstration projects to determine the effectiveness of these programs. The success of these programs paved the way for increased funding, which was increased in the Budget for Fiscal Year 2000-2001 to total approximately $55 million. Chapter 518, Statutes of 2000 added additional language that allowed for expansions of the existing programs and permitted additional counties to participate in these programs. Currently, 26 counties have been funded including the three initial pilot programs.

Recommendation: The State should fully fund programs that prove to be successful in providing outreach, mental health care, and follow-up services, such as the programs established by Chapter 617, Statutes of 1999 (AB 34).

Problem: Lack of law enforcement training, diversion programs, and discharge planning to treatment programs.

Mentally ill offenders (MIOs) are persons with mental illness who commit a crime and enter the criminal justice system. These people may become involved with the criminal justice system because of a lack of services, homelessness, or substance abuse. Many are detained or arrested for a variety of petty crimes, such as shoplifting or creating a public nuisance. Some may be detained for crimes that are more serious. Often, law enforcement officers will detain these persons in order to divert them into the mental health system rather than arresting them with a misdemeanor such as disturbing the peace, trespassing, and vandalism. However, with the limited availability of mental health resources, law enforcement officers are frequently unable to find alternatives to incarceration.

The Los Angeles Task Force on the Incarcerated Mentally Ill also found that "there are some persons that require secure correctional detention and who should receive appropriate mental health services within the jail. It is imperative, however, to develop cost effective and humane strategies for diversion of minor offenders to mental health settings and to provide them with the necessary community support systems, including housing, to prevent recidivism." (Los Angeles County Task Force on the Incarcerated Mentally Ill, 1993, page 18).

Pre-Booking Interventions

Pre-booking interventions usually occur at the scene of an incident. Pre-booking interventions require that police officers be trained in crisis intervention. Some counties have developed accredited training through Peace Officers Standards and Training (POST). In Monterey and Santa Clara counties, this 40 hour training course teaches law enforcement officers to make appropriate decisions when confronting a person with mental illness who is in crisis or who is acting dangerously without having to resort to force. In addition, non-uniformed mental health professionals may be employed by or under contract to local law enforcement agencies to assist patrol officers to respond to incidents. Mobile community mental health center employees may respond to such incidents as part of a team with police. Mental health staff based at community mental health centers cooperate with police in responding to such incidents.

Post-Booking or Pre-Adjudication Diversion

Post-booking or pre-adjudication interventions take place once a person has been arrested or incarcerated. These diversion programs usually require an offender to comply with a plan in order to be released. A public defender, court officials, and mental health officials may develop a release plan and present it to the judge at the initial court hearing. The judge may withhold final disposition of the case for a period of time to ensure the client's compliance with the release plan.

Recommendation: Counties should advocate for all law enforcement officers to attend the POST-accredited 40-hour training course on mental health.

Recommendation: The DMH and other appropriate state entities should develop and provide grants to counties to implement diversion program pilot projects.

Problem: Lack of appropriate care of mentally ill offenders in jails.

The jail environment is not conducive to helping a person with mental illness. The local jail frequently does not have adequate staffing to provide the screening needed to identify offenders with mental illness. The jails are overcrowded, often exacerbating the problems being experienced by the mentally ill offender. Jail staff frequently lack training in dealing with persons with mental illness. During the booking process, most jail

settings do not provide enough crisis management. The number of mental health staff in the jails is insufficient to provide mental health services; staff can only triage the most serious cases and dispense psychotropic medications. Many inmates are released before their request for mental health care can even be met. Release planning is insufficient. Mentally offenders are often released unsupported into the community only to reoffend. Jail is meant to punish or control and is not meant for the care of a person with serious mental illness.

Another major problem for mentally ill offenders is that the prescription drug formulary for jail medical services is outdated and does not include the newer psychotropic medications. A change in medication can cause further destabilization and impede any progress that has been made if an offender was being treated with the newer psychotropic medications.

Recommendation: Counties should develop effective policies and procedures for securing the safety of individuals who have been diagnosed with mental illness to improve the quality of mental health services in their jails. These policies should include the following:

- The local law enforcement agency should routinely screen all incoming detainees for mental illness.
- Additional positions should be provided in jail to enable jail mental health staff to respond to requests for mental health services, provide mental health interventions, and participate more fully in release planning.
- The jail medical formulary should include all of the latest psychotropic medications in order to ensure consistency with what the client is already taking and to ensure compliance.

Recommendation: Counties should adopt effective policies and procedures for screening and identifying all inmates for mental disorders, for providing appropriate mental health services, and for seamless transition into the community after release.

Mentally Ill Offender Crime Reduction Program

Chapter 501, Statutes of 1998 (SB 1485) established the Mentally Ill Offender Crime Reduction (MIOCR) program through the Board of Corrections. This program provides four-year grants to county sheriffs to help support mentally ill offenders during incarceration and provide appropriate support for these offenders upon release. These programs also are helping to build relationships between law enforcement and mental health by providing community mental health services to people who would otherwise be released from jail with no mental health support and who would be likely to be re-arrested shortly thereafter.

The Budget Act for Fiscal Year 2000-2001 provides approximately $50 million to the Board of Corrections for this program, bringing the total amount of funding to $100 million, which is the total amount of funding requests submitted by counties in 1999.

Recommendation: If the MIOCR programs are proven effective, the State should fund these projects in any remaining county that does not have a program.

Problem: Limitations of the Local Court Systems

Most local court systems have limitations in their dealings with mentally ill offenders. Judges are often at a loss as to appropriate sanctions and punishment, and community treatment options are few or unavailable. A lack of coordination is evident when an inmate is released. For example, family members and community-based service providers are not informed of the date and time of a court hearing for a client they had supported or housed prior to incarceration. Many times, the judge will order an inmate's immediate release, which can take place in the early morning hours, without notifying anyone about the release.

Recommendation: Court officials should receive training to help identify, understand, and deal with persons with mental illness and with persons who have a mental illness and co-occurring mental illness and substance abuse disorder.

Recommendation: All counties should establish an Interagency Policy Council, which includes the Mental Health Department, Alcohol and Drug Department, Sheriff's Department, Police Department, Probation Department, Superior Court, District Attorney, Public Defender, Housing Authority, Department of Social Services, Department of Health Services, Parole Department, Rehabilitation Department, clients, and family members. The duties of this council would be to coordinate discharge planning, provide consistent treatment of clients in jails, and to implement and expand diversion programs.

DRAFT

Problem: Persons with mental illness are stereotyped by the public as being violent.

A recent study on violence and mental disability found that almost two-thirds of the public say they believe persons with schizophrenia are prone to violence against others (Monahan,). In many cases, people who have psychiatric diagnoses are being scapegoated for society's violence when, in fact, these people are more likely to be victims of crime or suicide. In actuality, persons with mental illnesses account for a very small percentage of the violence in American society. "The prevalence of violence among people who have been discharged from a hospital and who do not have symptoms of substance abuse is about the same as the prevalence of violence among other people living in their communities who do not have symptoms of substance abuse" (Monahan, 1998). In fact, the study concluded that only 3 percent of violence in American society comes from persons with mental illnesses.

The public's perception that persons with mental illness are violent is exacerbated by the increasing number of persons with mental illness who are involved with the criminal justice system. In addition, some advocates believe that the association of violence with mental illness is being actively promoted publicly, playing off people's fears for public protection in order to increase resources and funding for the mental health system.

Recommendation: The Legislature and the DMH should implement a campaign to help educate the public about the misperception of the relationship between violence and mental illness.

Social Support Network

A program description from the Long Beach Village Integrated Services Agency, entitled "The Village Concept," observes that the needs of persons with mental illness for social support are no different from those of most people. After the basic needs of food, shelter, and clothing are met, the need for friendship and social interaction become apparent. When sufficient opportunity is provided to meet these needs, the individual has a sense of being embedded in a larger community. The individual develops a sense of dignity, self-worth, and belonging by having a definite role to play and a place in which to be and to grow.

Socializing and recreation teaches people social skills, provides them with leisure-time activities, and offers them involvement in community activities. Holshuh makes the following observation about how mental illness interferes with these natural processes:

> For persons with severe and persistent mental illnesses, onset of mental illness, acute episodes of symptoms, hospitalizations, and ongoing impairments have interfered with social development – forming relationships, making friends, getting married, getting and giving emotional support, and relating as adults with their families, employers, and landlords. In addition, these clients are a vulnerable group in need of but often lacking social support systems (Holshuh, 1992).

Consumer-Operated Service Programs

The self-help movement grew out of the idea that individuals who have experienced similar problems, life situations, or crises can effectively provide support to one another. Consumer-operated service programs offer support based on first-hand experiences with issues such as medication, social security and other income supports, housing, employment, human service agencies, families, and friends. These groups are formed by peers. They offer emotional support, friendship, individual advocacy, information about mental health issues, and a way to improve the mental health system.

> Consumer-operated programs include drop-in centers, case management programs, outreach programs, businesses, employment and housing programs, and crisis services, among others. Consumer staff are thought to gain meaningful work, to serve as role models for clients, and to enhance the sensitivity of the service system to the needs of people with mental disorders (Long, 1988).

A peer-run drop-in center provides an open, comfortable setting and often serves as the nucleus for a wide variety of support, service, and socialization activities. Services include self-help groups; training in independent living skills; advocacy and assistance in locating needed community resources and services, such as housing and financial aid; education about patients' rights, psychiatric drugs, and other topics of interest; social and recreational activities; and community or public education on mental illness.

Recommendation: The Governor and the Legislature should provide funding to ensure that consumer-run programs and peer supports are included as components in all local mental health services.

Recommendation: The State should provide training and technical assistance to local mental health programs to teach clients leadership, advocacy, and how to start and operate a peer support program.

Recommendation: The Planning Council should study the extent to which mental health systems support opportunities for consumers to develop consumer-run services.

Family Self-help

Many persons with mental disabilities live with or in life-long contact with their families. Many look to their families for moral support as well as for specific help in their individual recovery. Families can make significant contributions in assisting clients in treatment planning, health and dental care, consumer rights and advocacy, crisis response, and housing. Many times, families act as unofficial "case managers."

Many county mental health departments have hired a "Family Advocate" to act as a coordinator and resource person for families. This action has helped to ensure that families are involved in all stages of service delivery, when desired by the client.

Recommendation: Family Advocates should be employed by both county-operated mental health programs and community mental health agencies.

Recommendation: The mental health system should provide families education and support to help them understand their family member's illness and how best to provide support to that family member.

Problem: Lack of respite services for family members of persons with mental disabilities.

Family members of persons with mental disabilities also need support and respite services. They are under a great deal of stress caring for and obtaining resources for their family members who are mentally ill. Family members also feel stigmatized by society's attitude toward their family member's illness. Support organizations, such as NAMI California, help family members cope with the added stress and find available resources. In addition, family self-help groups result in better communication and interaction among family members.

In 2000 the Joint Committee on Mental health Reform (JCMHR) held a series of public hearings throughout the State to gather information and make recommendations about the mental health system. These hearings revealed that respite care is one of the highest unmet needs of family members who care for children and adults with serious mental illness. Lack of respite services results in caregiver "burnout."

Recommendation: The mental health system should provide respite services to family members of persons with mental disabilities.

Community Involvement

Problem: Lack of involvement and partnership by clients and family members in the mental health system.

During the Joint Committee on Mental Health Reform (JCMHR) hearings, a recurrent theme kept surfacing that clients and family members felt a lack of respect and partnership in the mental health system as well as a lack of access and a meaningful role in system design and implementation. The JCMHR also heard repeatedly from clients and families who had benefited through peer support activities, including self-help programs and family support programs. Through the support of family and peers, clients begin to become more involved in their community. Many clients have become community activists, helping other clients to navigate the human services system in their community.

Clients are becoming a political force. Campaigns to register to vote are underway as well as voter education to enable clients to vote for the candidates and measures that will benefit their lives the most. Clients are also volunteering in their communities for a variety of service-oriented tasks. Becoming involved in the community makes recovery a tangible goal.

Recommendation: The DMH and local mental health programs should provide training and resources to help clients and their families have meaningful involvement in the design and implementation of mental health programs.

Recommendation: The mental health system should develop specific ways to integrate persons with mental disabilities into the community, including joint projects with civic groups; education of the community by family, client and professional organizations; and media coverage and presentations to legislators, civic and business organizations, community agencies, and schools concerning mental health issues.

Protection and Advocacy

The protection and advocacy function weighs on all considerations in the provision of mental healths services, including neglect, abuse, and civil rights, always striving to balance a client's needs, the parens patriae responsibility of the State, and the State's obligation to the public for its safety. A description of mechanisms to protect the rights of persons with mental disabilities in all situations related to those disabilities is included in Appendix II.

CONCLUSION

The system of care for adults in the public mental health system should be recovery-oriented, empowering clients to develop the skills and acquire the supports and resources they need to succeed where they choose to live, learn, and work. The public mental health system should support, to the greatest extent possible, the six aspects of a client's life, which include health, living situation, productive daily activity, financial status, legal issues, and social support network. The recommendations made in this chapter relate directly to these areas of a client's life and will support clients in their treatment and recovery.

DRAFT

APPENDIX I

SYSTEM OF CARE CONTINUUM FOR ADULTS

Mental Health Treatment

1. Comprehensive Evaluation and Assessment Services To Identify Needs

   - health and dental needs, including overall physical health and mental health;
   - income support, including entitlements;
   - vocational and employment needs;
   - social support network;
   - socialization needs and resources;
   - survival skills (budgeting, peer support, transportation);
   - linkages to community;
   - AIDS testing and information; and
   - determination of a co-occurring disorder, including developmental disability; neurological disorder, or substance abuse.

2. Medication Education and Management

   Psychoactive medications in many cases are a beneficial and essential component of effective treatment. However, they may also have harmful effects, the long-range impact of which may be severe and irreversible. Therefore, mental health programs should support clients' attempts to function at the lowest possible dosages or even without psychoactive medications, if possible.

   Prior to prescribing medications, clinicians should educate a client and family members on symptom management and the role of psychoactive medications, including the nature of side effects and interaction of the medication with drugs and alcohol. In addition, education should include physical health effects, such as risk of increased cholesterol level and triglicerides.

   Medication management services should be provided, including prescriptions, access to the most efficacious medications, and monitoring to assure maximum effectiveness and to minimize adverse side effects.

   Staff should be trained in non-pharmacological responses to crises and should use these techniques as the treatment of choice if they are the client's choice and in the best interest of the client's health and safety.

3. Supportive Counseling and Therapy

   This service includes individual and group therapy services and more intensive support and counseling in 24-hour treatment programs. It also includes both short-term counseling and rehabilitation counseling. Supportive counseling can be provided by staff other than psychotherapists, including staff who demonstrate competency working with multiple disabilities, such as substance abuse, AIDS, developmental disabilities, and head injuries; job coaches, community-living counselors; rehabilitation program staff; and peer support groups.

4. 24-Hour Treatment Services

   The goal of these services is to reduce reliance on unnecessary and costly institutional care for persons with mental disabilities by developing a range of alternatives providing treatment and rehabilitation in non-institutional settings. Residential treatment programs, ranging from acute alternatives to supported apartment living, can minimize using institutional care in any community system. Hospital and services in institutions for mental diseases (IMDs) should be provided only to those persons who require medical care or institutional settings.

   A. 24-hour, Acute, Sub-Acute, Medical, or Intensive Care

DRAFT

1. Persons To Be Served

   This level of care is appropriate for both voluntary and involuntary treatment of persons with severe and acute mental disabilities, who may also be HIV positive, have AIDS, or have a head injury often with associated medical problems.

2. Description of Services

   Both hospital and non-hospital settings that meet Title 9 inpatient staffing standards can provide this level of care.

   Residents in IMD facilities should be considered residents of their county of origin unless they choose residency in the county in which the facility if located. In either case, they should be fully integrated into the local community mental health system.

B. Crisis/Acute Residential Treatment Program

1. Persons To Be Served

   This program serves anyone in the general community with a psychiatric concern or emergency, including persons needing information about services and referral or needing advice about dealing with someone in a psychiatric emergency.

2. Description of Services

   Walk-in services may be limited to business hours five days per week; however, call-in services shall be available 24 hours per day, 7 days per week.

C. 24-Hour, Transitional Residential Treatment

1. Persons To Be Served

   a) Persons not requiring acute, 24-hour services but who are not yet stable enough of sufficiently high functioning for independent living with less than 24-hour staff support onsite.

   b) persons who have become dependent or institutionalized and who need assistance to achieve or return to independent living. Time in this setting may be longer for people with severe multiple diagnoses.

      Clients would be referred from acute residential programs, inpatients hospitals, state hospitals, and IMDs. Others might come from board and care homes, family environments, or transient living situations.

2. Description of Services

   Transitional residential treatment programs include intensive programs with a full, on-site day treatment programs and those providing day programming off-site. Both types of transitional programs are certified by the State Department of Mental Health 9DMH) and licensed by the State Department of Social Services (DSS) as social rehabilitation residential treatment programs. Currently, these programs require that a length of stay not exceed a certain amount of time.

   Services in intensive, transitional programs include thorough diagnostic work and assessment of potential learning disabilities, full day treatment programs with active pre-vocational and vocational components, special education services, outreach to develop linkages with the social service system, and counseling to aid clients in developing skills to move toward a less structured setting.

   Services in less intensively staffed transitional programs emphasize providing counseling and support. Services in this program include ongoing assessment, developing community support systems, and encouraging socialization and utilization of general community resources. Both types of transitional programs should have access to services for substance abuse, AIDS, developmental disabilities, head injuries, and peer support.

Crisis Response Services

Crisis services provide immediate response 24 hours per day, seven days per week to individuals in crisis and to members of the individual's support system. The primary focus of crisis services is stabilization, crisis resolution, assessment or precipitating and attending factors, and recommendations for meeting identified needs.

The minimum goal of crisis intervention is resolving an individual's immediate crisis and restoring at least the level of functioning that existed before the crisis. An even better outcome would be to improve a client's functioning above the pre-crisis level.

A comprehensive crisis response system includes the following:

- 24-hour telephone service;
- mobile outreach services providing care wherever the crisis is occurring;
- walk-in service at local mental health agencies;
- crisis/acute residential treatment programs;
- inpatient care for those who require medical or physical attention or who require the safety of an institutional setting; and
- identification of contributing substance abuse, presence of AIDS, developmental disabilities, or head injuries.

For many, crisis response services are the initial contact with the public mental health system. For others, these services provide a safety net when needs emerge an all other treatment, rehabilitation, and support services are unavailable. All modes of crisis service must respond to clients and their families in a manner that is accessible, sensitive, and appropriate to the cultural and linguistic needs of the individual and community.

1. Emergency Services Evaluation

   A. Persons To Be Served

      Emergency evaluation is needed by persons experiencing acute psychiatric symptoms; persons who are suicidal or potentially violent; persons in panic states who are confused, behaving bizarrely, hallucinating, or otherwise so disturbed that they cannot care for their own physical needs; and persons exhibiting psychotic behavior due to acute drug or alcohol intoxication.

   B. Description of Services

      This service provides emergency evaluation and treatment 24 hours per day, 7 days per week. A preliminary assessment shall be made and treatment initiated, usually mediation and crisis intervention. After initial assessment and treatment, clients may be referred to a variety of programs, including crisis residential programs, support housing, day treatment centers, sub-acute facilities, other supportive environments, or other appropriate services in the community. These programs can effectively divert from inpatient services persons who would otherwise be routinely admitted to acute inpatient programs.

2. Crisis Intervention: Walk-in and Call-in Services

   A. Persons To Be Served

      This program shall serve anyone in the general community with a psychiatric concern or emergency, including persons needing information about services and referral or needing advice about dealing with someone in a psychiatric emergency.

   B. Description of Services

      Walk-in services may be limited to business hours five days per week; however, call-in services shall be available 24 hours per day, 7 days per week.

3. Mobile Crisis and Outreach Service

A. Persons To Be Served

Persons experiencing acute psychiatric symptoms who are unable to unwilling to go to crisis services are eligible.

B. Description of Services

The service is provided 24 hours per day, 7 days per week to go wherever a person is in crisis to and work intensively to resolve the situation without using other emergency settings. Services include crisis intervention, family work, developing a specific plan, referral to other resources, and coordinating resources on a short-term basis. The service shall be designed to maximize using the home environment and the natural support system to achieve stabilization.

Trained, compassionate response teams composed of nurses, clients, psychologists, social workers, and family members should be established to respond to crises effectively without force. Response time shall be as immediate as distance will allow. Compassionate response teams may prevent a crisis from deteriorating further to a situation requiring involuntary treatment and acute hospitalization.

Mobile crisis services must develop strong collaborative working relationships with all local law enforcement entities. Mobile crisis services can assist local law enforcement agencies in situations involving persons who may be experiencing a mental health crisis. When the assistance of law enforcement is required, officers will wear plain clothes whenever possible.

4. Crisis/Acute Residential Treatment Program

A. Persons To Be Served

Individuals with severe and acute mental disabilities who do not require or desire continuous medical supervision can voluntarily participate in the program. Depending on the staffing and design of individual programs, crisis residential programs are appropriate for a full range of non-medical acute distress, including suicidal and potentially violent clients, as well as people experiencing significant situational distress.

B. Description of Services

Crisis/acute residential treatment is provided in home-like settings in the community. These programs are certified by the DMH and licensed by the DSS as social rehabilitation facilities. Family care settings with sufficient resources for supervision and support can also provide an alternative to acute care.

The program's services include counseling and crisis resolution; working directly with families; referring clients to pre-vocational and vocational programs; and enhancing a support system, including referrals to income support programs, treatment services, and rehabilitation programs.

5. 24-Hour, Acute, Medical, Intensive Care

A. Persons To Be Served

Persons with severe and acute mental disabilities are served either voluntarily or involuntarily in this level of care. These individuals sometimes have associated medical problems, substance abuse, or other disabilities.

B. Description of Services

This level of care meets Title 9 inpatient staffing standards and is provided in hospital settings.

Service Coordination (Case Management)

Persons with mental disabilities may need help in securing resources in important life domains, such as employment, housing, education, social support, health care, and other services. Case management helps individuals obtain services they want and need. Case management is recognized as a critical role in an effective community support system. The Integrated Services Agency (ISA) model and the Assertive Community Treatment (ACT) model are two types of programs that provide intensive case management. Services to

individuals are coordinated through an individual or team that functions as the single point of responsibility for all needs, helping individuals remain stable, increase functional capacity, and achieve a decent quality of life.

DRAFT

APPENDIX II

PROTECTION AND ADVOCACY FOR CALIFORNIA'S MENTAL HEALTH SYSTEM

The protection and advocacy function of the California's mental health system includes mechanisms to protect the rights of persons with mental disabilities in all situations related to those disabilities, including the following:

- Statements of rights of persons with mental disabilities;
- A clear authority for the protection of rights;
- Statutes and regulations;
- Enforcement of protections with penalties for non-compliance;
- Independence of advocates from providers;
- Access to persons with mental disabilities;
- Case reviews;
- Procedures for clients with grievances against facilities or providers;
- Funding for mechanisms for protection and advocacy systems;
- Procedures for informing persons with mental disabilities and their families of their legal rights and resources to assist in upholding their rights;
- A sufficient number of advocates who are bilingual and bicultural; and
- Advocates familiar with all laws and statutes affecting persons with mental disabilities or those with multiple disabilities.

Patients' Rights

Persons with mental disabilities have all of the rights listed below:

- The same legal rights and responsibilities guaranteed all other persons by the federal Constitution and laws, and the Constitution and laws of the State of California, unless specifically limited by federal or state law or regulations;
- A right to treatment services promoting a person's potential to function independently and provided in the least restrictive manner possible;
- Safeguards ensuring that the right to treatment is upheld upon admission to hospitals and upon consideration of involuntary commitment to inpatient or outpatient settings;
- A right to dignity, privacy, and humane care;
- A right to be free from harm, including unnecessary or excessive physical restraints, isolation, medication, abuse, or neglect. Medication shall not be used as punishment, for the convenience of staff, as a substitute for program, or in quantities interfering with treatment programs;
- A right to prompt medical care and treatment;
- A right to religious freedom and practice;
- A right to participate in appropriate programs of publicly supported education;
- A right to social interaction and participation in community activities;
- A right to physical exercise and recreations opportunities; and
- A right to be free from hazardous procedures.

Duties of Patients' Rights Advocates

Patients' rights advocacy seeks to protect and enforce the legal and human rights of persons with mental disabilities. A system of patients' rights advocacy should be independent of service providers, including county mental health departments, and should be responsible for protecting the constitutional, statutory, and human rights of all persons identified as having psychiatric disabilities. The following responsibilities are included:

- Information and Referral;
- Developing advocacy materials;
- Training professionals on basic rights;
- Educating clients on basic rights;
- Investigating complaints;
- Representing clients at certification review hearings;
- Enforcing basic LPS rights as described in Sections 5325 and 5325.1 of the Welfare and Institutions Code;
- Eliminating basic rights violations, including physical,. emotional, and sexual abuse, and eliminating aversive treatment plans;
- Investigating and resolving complaints from or concerning recipients of mental health services residing in licensed health or community care facilities regarding abuse, unreasonable denial, or punitive withholding of rights guaranteed under provisions in the Welfare and Institutions Code;
- Compliance with provisions of the Americans with Disabilities Act (ADA) prohibiting discrimination against clients participating in or benefiting from services offered by publicly or privately owned auditoriums, schools, gyms, parks, restaurants, theaters, retail stores, hotels, and medical offices;
- Compliance with the ADA's provisions that employers may not discriminate against people with mental disabilities if they are qualified for a job. Employers shall provide reasonable accommodations to employees with mental disabilities; and
- Compliance with the Federal Fair Housing Amendments Act, which prohibits discrimination in housing for disabled person, including persons with mental disabilities.

Duties of the State

The state promotes advocacy activities on behalf of persons with mental disabilities by taking the following actions:

- Ensuring that individuals and families receive appropriate services, benefits, and protections;
- Improving at the systems level services, benefits, and rights for all persons with mental disabilities;
- Ensuring compliance with the Protection and Advocacy for Mentally Ill Individuals Act of 1986, which requires states to establish protection and advocacy systems, including investigating incidents of abuse and neglect of persons with mental disabilities; and
- Ensuring compliance with Section 5500, et.seq. of the Welfare and Institutions Code, which establishes a statewide advocacy system.

The protection and advocacy function of a community support system includes the right of a client to receive treatment; to the extent possible, the right to participate in determining treatment; the right to be treated with competence, care, and consideration; the right to receive such treatment in both residential and non-residential settings that are the least restrictive and most appropriate for each clients and that are adequately staffed and equipped, and certainly the right to receive such treatment free of neglect and abuse.

DRAFT

CHAPTER 6

THE PLANNED SYSTEM OF CARE FOR OLDER ADULTS

WHAT ARE THE VISION, MISSION AND VALUES FOR THE SYSTEM OF CARE FOR OLDER ADULTS?

The mental health constituency envisions a society in which older adults live in families[3] that support and value their ability to be happy, healthy, and resilient. The public mental health system promotes this vision through participation in a community-based system of care, which fosters a life-span approach. The purpose of creating a public mental health system that collaborates with the social, health, and long-term care systems of care is to accomplish the following goals for older adults and their families:

- older adults are healthy;
- they are safe;
- they live at home;
- they engage in meaningful and productive activities;
- they have supportive relationships with others;
- they have meaningful connections to their communities; and
- they abide by the law.

Counties may be in different stages of implementation or may have different needs for mental health components outlined in this chapter. The following values should guide counties when implementing the older adult system of care:

Access to Community-based Services. Because older adults have unique problems that limit their capacity to access services, such as lack of mobility, social isolation, sensory losses, and development of age-associated physical problems, access to services must include mobile outreach services. Mental health services should be provided in the least restrictive, most natural setting possible, including senior centers, housing programs, nutrition sites, nursing facilities, and other residential and community settings.

Client Strengths. Services should focus on assets and strengths of older adults and on using those strengths to help older adults retain a sense of identity, dignity, and self-esteem.

Empowerment. Services should be provided in a manner promoting the fullest possible personal control over one's life.

Self-help. Continued effort should be made to develop service systems, such as peer counseling programs, that focus on self-help and use older persons as mental health service providers.

Preventing Inappropriate Institutionalization. Systems of care must place a high priority on providing services to older adults with serious mental illnesses at risk of inappropriate institutionalization, especially older women with mental illness who are at greater risk of institutionalization than their male counterparts. When institutionalization cannot be prevented, it should be for the minimum length of stay needed to achieve a therapeutic outcome.

Preventing Suicide. Services should provide for appropriate screening and assessment for depression and other risk factors, signs, and symptoms associated with suicide among older adults.

Support Services for Caregivers. Support services should be provided for caregivers of older adults since burn out of caregivers has been identified as the single most important factor contributing to premature institutional care.

---

[3]The term "family" is used in its broadest sense to include any adult engaged in supporting the older adult in their life.

DRAFT

Family and Community Involvement. Involving families in planning, implementing, and evaluating programs for older adults is a crucial element. Services should take place in an environment that includes family, friends, clergy and the spiritual community, and other informal support groups.

Cultural Competence. Services should be provided in a manner respecting a client's culture of origin, particularly for older adults who have strong ties to cultural approaches to mental and physical health care. Staff composition should reflect the ethnicity of the client population.

Multidisciplinary Service Coordination. Older persons with multiple problems, such as mental illness, physical disabilities, and substance abuse, may encounter multiple service providers; therefore, mental health planning requires multidisciplinary service coordination. Communities must establish formal linkages among providers of health care, social services, aging services, drug and alcohol programs, developmental disabilities services, and mental health services.

Assessment and Treatment Protocols. Assessment, treatment protocols, and guidelines should be age-appropriate and gender-appropriate. Services should meet the special needs of older women and reduce the barriers to services they face, including poverty, isolation, failing health, and substance abuse.

Multiple Funding Sources. Service availability for older adults will require using all funding resources available to meet the mental health needs of older adults, including federal, state, local, and other third-party payers.

Medical/Psychiatric Interface. Physical problems can cause or contribute to mental impairment. The system of care should strive for an integrated, cost-effective diagnostic and treatment interface between the physical health care system and the mental health care system. Difficult medical cases should be handled through appropriate referrals.

WHAT ARE THE TARGET POPULATIONS FOR THE SYSTEM OF CARE FOR OLDER ADULTS?

The public mental health system is responsible for ensuring that services are available to the target population. Functional impairment and acuity of the mental disorder presented by the older adult should establish priority access to mental health services. The target population, comprised of older adults age 60 and over, has three components: severely and persistently disabled older adults, acutely disabled older adults, and older adults affected by disasters and local emergencies. Other populations need mental health services as well. If additional resources are made available, the public sector should also provide services to emerging groups with special needs.

Group I--Older Adults with Serious and Persistent Mental Illness

This population is defined along four dimensions: diagnosis, functional impairment, duration of the illness, and financial assistance. Individuals with serious and persistent mental illness are expected to have life-long needs for mental health services and support. With mental health support, these individuals can successfully remain in the community. Older adults in this group may reside anywhere, including in their own home, retirement facilities, assisted living facilities, residential care facilities, skilled nursing facilities, locked skilled nursing facilities, or institutes for mental disease. These individuals may also reside with family members, in the criminal justice system, or on the streets.

A. Diagnosis

An older adult must be diagnosed with a serious and persistent mental disorder as defined by the latest *Diagnostic and Statistical Manual of Mental Disorders* (DSM), Medicare, and Medi-Cal criteria of diagnostic categories and physical problems that contribute to mental illness. Persons with dual diagnoses meet this criteria by having co-existing diagnoses of serious mental illness with a secondary diagnoses of developmental disability, substance abuse, brain trauma, or delirium, dementia, amnesia and other cognitive disorders and mental disorders due to a general medical condition.

B. Functional Impairment

An older adult will be substantially impaired in major life activities because of a mental disorder. An older adult will be impaired in one of the following areas on a continuing or intermittent basis: independent living, social and family relationships, self-care capacities, physical condition, vocational skills and employment, living skills, or money management.

C. Duration of the Illness

Persons with serious and persistent mental illness in Group I are expected to require mental health services for an extended period. An individual would have a treatment history meeting at least one of the following criteria:

1. has undergone psychiatric treatment more intensive than outpatient services, e.g., crisis response services, residential care services, partial hospitalization, or inpatient hospitalization; or
2. has experienced an episode of continuous residential or institutional care with mental health supports other than hospitalization for a period long enough to disrupt the normal living arrangement significantly.

D. Financial Assistance

Older adults with serious and persistent mental illness may receive Supplemental Security Income or Supplemental Disability Income. However, the older adult may have multiple health insurance plans, including public and private insurance providers. Many times exclusionary rules involving diagnosis or type of service make providing service to this group of older adults through their insurance or Medicare extremely difficult.

Group II--Older Adults with Acute Mental Disorders

This group includes persons with acute mental disorders, including anxiety, depression, or other mental disorders due to a traumatic event or loss, placing them at risk of serious mental decompensation. Acute is defined as needing mental health services for a short period of time to reduce symptoms, which put the individual at risk of inpatient care.

A. Diagnosis

An older adult must have a diagnosed mental disorder as defined by the latest DSM, Medi-Cal, and Medicare criteria. Prior treatment history is not required.

B. Functional Impairment

Individuals in Group II will exhibit high-risk behaviors putting them at risk of inpatient hospitalization due to a mental disorder. These behaviors include a danger to self, danger to others, or gravely disabled.

C. Duration of the Illness

Acute mental disorders are expected to require mental health services for a limited period to re-establish stability.

D. Financial Assistance

Individuals with acute mental illness may have multiple health insurance plans, including public and private insurance providers. Many times exclusionary rules involving diagnosis or type of service often make providing services to this group of older adults through their insurance or Medicare extremely difficult.

Group III--Disaster Response for Older Adults

The target population includes persons traumatized by a natural disaster or other local emergency. Older adults are particularly affected by these events because of problems with mobility and physical illness. Responses required from mental health workers may vary in type and duration. Specialized efforts to serve this population are required for any local emergency and disaster.

Other Populations Requiring Mental Health Care

If additional resources are made available to the mental health system, other populations should receive publicly funded mental health services, including persons with adjustment or other disorders who do not have acute or high-risk symptoms. These persons would usually benefit from outpatient or peer counseling services. Unless they receive mental health services, they sometimes become members of the target population. These persons do not have a DSM diagnosis of a serious mental disorder. Wellness programs reaching older adults who are not currently ill but who might become ill at some point would also be beneficial should additional funds become available. These programs might include educational efforts for older adults on how to deal with bereavement and other issues.

DRAFT

WHAT ARE THE MAJOR PROBLEMS AND NEEDS OF OLDER ADULTS WITH SERIOUS MENTAL ILLNESSES?

Older adults are one of the most underserved groups in California's mental health system, yet they are the fastest growing segment of the State's population. The incidence of psychosis among older adults is more than double the rate for individuals 20 to 35 years of age (Cohen, 1980). Fourteen percent of California's population is 60 years of age and older. By the year 2010, the first influx of baby boomers will constitute 29.2 percent of California's total population over 60 years of age. By the year 2020, baby boomers will constitute 70.2 percent of California's total population over 60 years of age. By the year 2020, older adults will represent 21 percent of California's total population. The National Institute of Mental Health reports that about 15 percent to 25 percent of persons over age 60 will require some form of mental health services. The actual rate at which older adults use mental health services nationally is unknown due to lack of adequate, valid data.

Older adults have special problems that must be considered in developing the types and mix of services to be provided. Among these problems are substance abuse and misuse; sensory loss; homelessness; economic hardship; cognitive impairments; decreasing physical mobility; increasing physical and bio-chemical impairments; nutritional status; comorbidity; vulnerability to overmedication; and loss of interpersonal, social and family support networks that make treatment more complex.

Older adults have a wide range of mental health problems, including depression, which if not properly diagnosed and treated frequently result in high suicide risk and a functional disorder resembling dementia. Indeed, men over the age of 75 have the highest suicide rate in the population. Despite the severity and prevalence of mental disorders among older adults, most of them do not access mental health services. Barriers to mental health care for older adults include:

- the stigma this age group associates with mental illness;
- isolation of older adults;
- lack of accessibility, availability, and visibility of services;
- lack of transportation;
- lack of staff adequately trained to provide age-appropriate services; and
- prevailing myths regarding inability of older adults to benefit from mental health intervention; and
- lack of adequate integrated assessment of mental and physical problems that contribute to impaired mental functioning.

As adults with psychiatric disabilities age, they have an increase in illnesses and injuries, which often result in permanent or temporary physical disabilities. As this population frequently lives alone or in group housing situations, family support is often unavailable to provide temporary or permanent care to allow the individual to remain in their own housing. As the amount of publicly-funded in-home support services (funded under county social services departments) and home health services (funded by Medi-Cal or Medicare) is severely limited, older adults with psychiatric disabilities who experience illness or injury are frequently forced into residential care, institutions for mental disease, or convalescent hospitals to receive this level of care.

WHAT SERVICES AND PROGRAMS SHOULD BE PROVIDED TO OLDER ADULTS WITH SERIOUS MENTAL ILLNESSES?

In developing a system of care, these minimum service standards are required: early detection and prevention; mobile and clinic-based outreach, assessment, and treatment; medical screening; crisis intervention; medication services, including education about medication management and symptoms; service coordination; day treatment services; 24-hour acute care; community support and rehabilitation; senior peer counseling; and residential services.

A system of care for older adults must include a comprehensive medical and psychiatric model. For older adults suffering from multiple and severe illnesses, service coordination will be increasingly important as well as the interface with medical providers. As symptoms increase in severity, older adults experience reduced mobility and have an increased need for mobile services. For older adults, home-based mental health services are the most cost-effective compared to the high cost of hospitalization or emergency room visits.

DRAFT

Table 1, which follows, lists all the services that should be in place in each county in order to have a comprehensive system of care for older adults. This table describes the optimal system of care; however, no county has implemented such a full range of services. Service providers should be cognizant of ethnic, cultural, and linguistic issues and should integrate these issues into mental health services. The following principles should be considered in developing services for older adults:

- Older persons can respond to psychotherapy and other forms of counseling and rehabilitation treatment;
- Degenerative brain disorders are a disease process and not a normal process of aging;
- A complete psychiatric assessment for older persons must include a physical and psychosocial evaluation;
- A multidisciplinary team approach is essential in diagnosing and delivering mental health services;
- Programs for older adults must provide transportation for clients and staff to ensure frail or homebound older adults receive services;
- A comprehensive array of services will include service coordination and family support, when available, to ensure continuity of care throughout treatment and appropriate coordination with social support services and medical treatment;
- All programs should have available staff who are specifically trained in caring for older adults;
- Older adults need community-based, long-term care services. In-home mental health services should be provided and coordinated with physical health care resources. Adult day health care should be emphasized because it can help older adults remain in the community and also provides respite for family members.
- Counties should develop peer support groups and outpatient treatment programs to prevent older adults from falling through the cracks or becoming more seriously ill. These services should be tailored to consumers in their natural support system.

WHAT ARE THE INTERAGENCY PARTNERSHIPS FOR THE SYSTEM OF CARE FOR OLDER ADULTS?

The need for coordination of services with a fixed point of responsibility is paramount. Many services to older adults with mental illness as well as physical health problems are delayed because of the lack of coordination between the mental health system and the medical system. Blended funding is needed to enable mental health providers to offer wraparound services to older adult clients. Concepts need to be changed to modify funding tracks, re-do carve outs with the State, and use blended funding at the local level.

There is broad agreement about the critical need to improve both the range and coordination of services delivered to older persons with mental health needs. Developing a comprehensive, coordinated system of care is a major goal. This system of care must include program and service components as well as structures or processes to insure that services are provided in a coordinated, cohesive manner.

A system of care is a comprehensive spectrum of mental health services and other necessary services. These services should be organized into a coordinated network to meet the multiple and changing needs of older persons. The system of care must be more than a network of service components. Rather, it should embody a philosophy about how services should be provided to older persons and their families. The actual components, organization, and configuration of the system of care may differ from community to community. Despite such differences, the values outlined in this chapter should guide the system of care.

Each service dimension in a system of care addresses an area of need for older persons and describes a set of functions that must be performed to provide comprehensive services to meet these needs. Table 1 provides a comprehensive inventory of interagency programs and functions for older adults by level of intervention. This table highlights all the interagency partnerships and agreements that are necessary components in a model system of care to ensure that older adults receive the services they need. Although a county mental health program may not provide all of the services listed, it should work in partnership with the organizations that are listed in Table 1 to ensure that these services are provided in each county. In different communities, different agencies can provide the various types of services. Many of these services can be provided through multi-agency collaborative efforts rather than by a single agency. Such collaborations are important not only in identifying needs and planning services but also in developing, funding, and operating services.

DRAFT

Table 1 identifies the needed components for a proposed system of care for older adults from prevention services to the most restrictive level of services and the agencies that would provide those services. Beginning with the most restrictive services, Level IV includes acute and subacute services, which would be provided by agencies such as the State Department of Mental Health (DMH), private practitioners, county mental health, and community-based organizations. Level III includes moderately restrictive services that are provided by county mental health departments and their contract providers, and other resources at the local level, such as the Area Agencies on Aging (AAA) and caregiver resource centers. For Level II services, all partners previously described are involved in the service delivery at this level, but the system of care expands to include other partners, such as private practitioners, health maintenance organizations (HMOs), and faith organizations. Level I includes prevention services and involves the broadest scope of partners from local agencies to state agencies, such as the State DMH, higher education, and Department of Aging.

Services to older adults require strong interagency partnerships between primary medical providers and mental health providers. Medication monitoring is an important part of this partnership. A comprehensive system of care for older adults will include family members and other informal support systems. Private sector facilities and practitioners can also play a pivotal role in the system of care, providing a wide range of services. Other partnerships include the aging network; social services, adult protective services; the judicial system; and home health agencies. Advocacy is increasingly important in this environment.

County Structures To Establish Interagency Partnerships

To encourage interagency collaboration with shared responsibility for services, each county needs to have an Interagency Policy and Planning Committee. The local mental health director should be responsible for facilitating the formation of a county interagency policy and planning committee. The members of the committee should consist of the leaders of participating local government agencies, including a member of the board of supervisors; the county counsel; and the directors of public health, social services, mental health, adult protective services, area agencies on aging, and in-home supportive services.

The committee should have the following duties:

(1) Identify those agencies that have a significant joint responsibility for the target population and ensure collaboration on countywide planning and policy.

(2) Identify gaps in services to members of the target population, develop policies to ensure service effectiveness and continuity, and set priorities for interagency services.

(3) Implement public and private collaborative programs whenever possible to better serve the target population.

Counties also need a mechanism for coordinating the care of specific clients. The local mental health director should facilitate the formation of a multidisciplinary care management team for older adults whose function shall be to coordinate resources to specific older adults who are using the services of more than one agency concurrently. The members of this team should include representatives from senior social services, alcohol and drug abuse, the conservator's office, mental health services agencies, adult protective services, area agencies on aging, in-home supportive services, and senior centers. These staff must have the necessary authority to commit resources from their agencies to an interagency service plan for older adults. The roles, responsibilities, and operation of these teams should be specified in written interagency agreements or memoranda of understanding.

Formal interagency agreements are necessary to ensure that interagency partnerships operate smoothly. The local mental health director should develop written interagency agreements or memoranda of understanding with the agencies listed below. Written interagency agreements or memoranda should specify services to be provided jointly, staff tasks and responsibilities, facility and supply commitments, budget considerations, and linkage and referral services. The agreements should be reviewed and updated annually.

The interagency agreements may be needed with any of the following county agencies:

(1) special senior service consortiums, boards, commissions and advisory councils;

(2) the court probate and conservator department;

(3) the county senior ombudsman office;

(4) the county public health department;

(5) the county department of drug and alcohol services;

(6) senior legal services;

(7) public transit authority; and

(8) other local public or private agencies serving older adults.

Department of Aging

Under the Older Americans Act, the California Department of Aging (CDA) serves as the State Unit on Aging responsible for the administration of various programs and services designed to meet the needs of adults and seniors through the efforts of 33 Area Agencies on Aging located throughout the State. In addition to serving in a leadership capacity, CDA is an advocate for home and community-based services for California's elderly population. The Area Agencies on Aging fund and monitor the provision of direct services in the areas of information and referral, legal services, nutrition (congregate and home delivered), in-home services, friendly visiting, escort and transportation, service coordination, day care, the nursing home ombudsman program, and respite. The CDA administers the Senior Employment Program, which is available to persons 55 years and over; the Multipurpose Senior Service Program serving persons over 65 who qualify for Medi-Cal; the Linkages program, which assists adults at risk of institutionalization; the Adult Day Health Care Program for persons 18 and over who require rehabilitative services; and the Alzheimer's Day Care Resource Center Program providing dementia-specific services to persons with cognitive impairments and respite for family caregivers. Other programs that could be supportive to persons with psychiatric disabilities include: Senior Companions, Foster Grandparents, Brown Bag grocery distribution services, the Health Insurance Advocacy and Planning Program (HICAP), and the Respite Registry Program. Local mental health departments could establish appropriate ties with these supportive services to assist older adults with psychiatric disabilities to function independently in the community.

State Level Initiatives

Aging with Dignity Initiative

In the Budget Act for Fiscal Year 2000-01, the Administration committed $271.5 million for the Aging with Dignity Initiative to help elderly people remain at home, or with their families, rather than in nursing homes. The intent of this initiative is to dramatically increase the availability of innovative community-based alternatives to nursing home care and enhance the quality of care in California's nursing homes.

Caregiver Training Initiative

The Caregiver Training Initiative was established pursuant to Chapter 108, Statutes of 2000 and funded by the Budget Act of 2000-01. The intent of the legislation is to develop and implement proposals to recruit, train, and retain health care providers such as certified nurse assistants, certified nurses, registered nurses, licensed vocational nurses, and other types of nursing and direct-care staff. The bill also creates an advisory council to develop goals, policies, and a general workplan for the Initiative. Membership includes representation from federal, state, and local level government, the health care and home care industries and organized labor.

Long-term Care Council

Chapter 895, Statutes of 1999, established the Long-term Care Council within the Health and Human Services Agency, to coordinate long-term care policy development across multiple departments and programs and develop a strategic plan for long-term care policy. The Long-term Care Council will develop strategies to improve quality and accessibility of consumer information on available long-term care programs.

Long Term Care Innovation Grants

The Administration has challenged foundations and private sector communities to partner with the State in an effort to dramatically expand innovative strategies and alternatives to nursing home placement. The Budget Act of 2000-01 includes a $14,250,000 one-time General Fund grant program to implement and expand community-based adult care alternatives to nursing homes. The Administration will be seeking a commitment from private foundations to fully fund these innovation grants each year for the next ten years.

DRAFT

TABLE I

PROPOSED SYSTEM OF CARE FOR OLDER ADULTS WITH SEVERE AND ACUTE PSYCHIATRIC DISABILITIES: NEEDED COMPONENTS

	Co. Mental Health	Local AAA	Local Health Svcs.	Local Social Svcs./ Humn. Svcs.	Local Hous-ing	Local Trans. Agncy	Drug & Alc. Svcs.	Comm. Based Orgs.	Public Guard/ Consrv	Priv. Prac. Prov.	HMOs	Law Enf.	Faith Orgs.	Voc. Social/ Rehab	Higher Ed.	State DMH	Care-giver Resrce Ctrs.	CA Dept. of Aging
LEVEL 1 (PREVENTION)																		
Information & Referral	X	X	X	X			X	X	X	X	X		X			X	X	X
Outreach/Aging Education	X	X	X	X			X	X		X	X		X			X	X	X
Outreach--Pre-Retirement Seminars		X		X				X									X	X
Transportation		X				X		X	X									
Other Aging Services. (e.g., Sr. Center, nutrition)		X						X		X			X					X
Friendship Phone Line	X	X					X	X			X		X				X	
Voc. Training/ Sr. Employment		X						X						X	X			X
Socialization		X		X				X			X		X				X	
Health Education		X	X				X	X	X	X	X			X	X		X	X
Family Support Groups	X	X					X	X			X		X				X	X
Medical Services for Differential Diagnosis	X		X				X	X		X	X							
Advocacy	X							X	X	X							X	
Money Management									X								X	

DRAFT

	Co. Mental Health	Local AAA	Local Health Svcs.	Local Social Svcs./ Humn. Svcs.	Local Hous-ing	Local Trans. Agncy	Drug & Alc. Svcs.	Comm. Based Orgs.	Public Guard/ Consrv	Priv. Prac. Prov.	HMOs	Law Enf.	Faith Orgs.	Voc. Social/ Rehab	Higher Ed.	State DMH	Care-giver Resrce Ctrs.	CA Dept. of Aging
Management																		
Assisted Living								X					X					
LEVEL II (LEAST RESTRICTIVE INTERVENTION)										X								
Peer Counseling	X	X	X				X	X					X				X	X
Outpatient Treatment Services	X		X				X	X		X	X							
Individual & Group Therapy	X						X	X		X	X							
Mobile Crisis	X		X				X	X			X							
"Walk-in Crisis"	X						X	X		X	X							
MH Services Advocacy	X	X					X	X	X							X	X	X
Day Habilitative Treatment	X	X						X		X	X						X	
Social Day Care		X					X	X									X	
Support Groups	X	X	X				X	X					X				X	
Respite Services	X	X		X				X		X							X	
In-home Supportive Services		X		X				X										
MH Services at Senior Centers	X	X					X	X									X	
Semi-independent/ Shared Housing	X	X			X	X		X										

DRAFT

	Co. Mental Health	**Local AAA**	**Local Health Svcs.**	**Local Social Svcs./ Humn. Svcs.**	**Local Hous-ing**	**Local Trans. Agncy**	**Drug & Alc. Svcs.**	**Comm. Based Orgs.**	**Public Guard/ Consrv**	**Priv. Prac. Prov.**	**HMOs**	**Law Enf.**	**Faith Orgs.**	**Voc. Social/ Rehab**	**Higher Ed.**	**State DMH**	**Care-giver Resrce Ctrs.**	**CA Dept. of Aging**
Elder Abuse/ Neglect Interagency Team	X	X	X	X		X	X	X	X	X								
Substance Abuse Services (Outpatient & Inpatient)	X		X				X	X		X							X	
Case Management	X	X	X	X			X	X	X	X	X		X					
Linkages Program		X						X										X
Regional Resource Centers	X							X								X		
Rehab Services									X		X		X	X				
In-Home Health Care								X			X							
Partial Hospitalization										X	X	X						
Hospice				X							X							
LEVEL III (MODERATELY RESTRICTIVE)																		
Intensive Day Treatment	X							X		X	X					X	X	
Alzheimer's/ Directed Day Care		X						X		X	X						X	X
Supervised Group Home	X	X		X			X	X										
Residential Care Facilities for Seniors	X	X		X			X	X										
Therapeutic Foster Care	X	X		X			X	X										

DRAFT

	Co. Mental Health	**Local AAA**	**Local Health Svcs.**	**Local Social Svcs./ Humn. Svcs.**	**Local Hous-ing**	**Local Trans. Agncy**	**Drug & Alc. Svcs.**	**Comm. Based Orgs.**	**Public Guard/ Consrv**	**Priv. Prac. Prov.**	**HMOs**	**Law Enf.**	**Faith Orgs.**	**Voc. Social/ Rehab**	**Higher Ed.**	**State DMH**	**Care-giver Resrce Ctrs.**	**CA Dept. of Aging**
Crisis and Transitional Beds	X			X			X	X		X								
Money Management.-- Rep./ Sub-Payee, Power of Attorney	X	X		X				X	X								X	
Acute Care-- Gero/Med. Psych. (Hospital or PHF)	X		X					X		X	X							
Adult Day Health Care		X						X								X	X	X
MSSP/Ombuds-man/Patients' Rights Advocate	X	X						X								X	X	X
LPS/Probate Conservatorships of Person or Estate	X			X				X	X									
LEVEL IV (MOST RESTRICTIVE)																		
Skilled Nursing Facility (SNF)	X		X					X		X						X		
SNF with Treatment Patch	X		X					X		X						X		
Secure Facility	X		X					X		X						X		
State Hospital	X															X		

WHAT ARE THE GOALS AND OBJECTIVES FOR THE SYSTEM OF CARE FOR OLDER ADULTS?

GOAL 1: To enact legislation creating a pilot program to implement an older adult system of care.

A. Sections in this chapter on target population definition, range of mental health services, and interagency collaboration can be used as components for the older adult system of care legislation

B. For each county awarded a system of care grant, the Department of Mental Health (DMH) shall establish system performance goals and negotiate the expected levels of attainment for each year of participation. Expected levels of attainment shall include a breakdown by ethnic origin and shall be identified by a county in its proposal. These goals shall include the following:

1) Establish a baseline for the following performance indicators for clients:

a) The extent to which ethnic minorities are served in proportion to their representation in the general population.

b) The rate at which homeless persons accept services.

c) The rate at which clients are actively engaged in some community support network as measured by participation in peer support or self-help groups or socialization center programs, or other activities.

d) The rate at which clients are participating in a rehabilitation program, as measured by membership in a psychiatric rehabilitation program, a supported employment program, volunteer programs, adult day and adult day health care programs for at least one year.

e) The rate at which multi-problem clients, including those with a secondary diagnosis of substance abuse and seniors with special needs, are receiving a comprehensive program of treatment that addresses their multi-diagnostic needs.

f) Psychological impairment and functioning for clients in the target population.

g) The rate at which clients receive income support entitlements.

h) The rate at which clients remain in the least restrictive, most appropriate housing consistent with their capabilities for at least one year.

i) The rate at which clients spend time in the local jails.

j) The rate at which clients with a secondary diagnosis of substance abuse are abusing dangerous drugs, prescription drugs, and over-the-counter medications.

2) Cost effectiveness indicators:

a) All major public costs for clients, including mental health, housing, social services, vocational and physical rehabilitation, health services (including Medi-Cal and Medicare), adult protective services, and public guardianship.

b) Costs for state hospitals, local acute inpatient facilities, skilled nursing facilities, institutions for mental disease, crisis residential, and medical facilities.

c) Costs for criminal recidivism.

d) Other short-term and long-term costs related to attaining client outcome goals.

3) Measure the extent to which the following system-level goals are attained:

a) The percentage of clients who meet the target population definition.

b) The extent to which the joint responsibilities specified in the interagency agreements have been fulfilled.

c) The percentage of clients with individualized service plans that will facilitate interagency service delivery in the least restrictive environment.

d) To ensure access by older adults to state hospitals, local acute inpatient facilities, skilled nursing facilities, institutions for mental disease, and medical facilities.

e) To develop or provide access to a range of intensive services that will meet individualized service plan needs. These services shall include, but not be limited to, the list of services in Table 1.

f) To ensure the development and operation of the interagency policy and planning committee and the multidisciplinary care management team.

g) To develop caregiver education and support groups and linkages to ensure their involvement in the planning process and the delivery of services.

h) To gather, manage, and report data in accordance with state requirements.

i) To ensure the development of assessment protocols for concomitant physical problems either causing or contributing to mental health impairments.

GOAL 2: Provide at the state and local levels training and education on the mental health of older adults to reduce stigma and increase public awareness.

A. By January 2002, local and state mental health and aging programs shall sponsor at least one training program for public and private professionals emphasizing treatment, pharmacological issues, differential diagnosis, ethnically and culturally relevant issues, and suicide prevention among older adults.

B. By June 2002, local and state mental health and aging programs shall sponsor training programs in nursing and residential care facilities on the mental health needs of their clients.

C. By January 2003, local and state mental health and aging programs shall sponsor an annual training conference on issues related to providing culturally relevant services to older adults who are members of ethnic minorities.

D. By June 2003, state and local mental health and aging programs shall develop educational programs for older adults that help them increase their understanding and awareness of mental health and aging issues.

E. By January 2004, local and state mental health and aging programs shall sponsor training for senior peer counselors and trainers in every county.

F. By June 2004, mental health professional licensing boards shall establish a minimum requirement of four hours of geropsychiatric training, including cultural competency issues.

GOAL 3: The DMH must work closely with the Department of Health Services to develop a coordinated response to the health needs of older adults.

GOAL 4: Housing should be developed which allows individuals to have a live-in caregiver.

GOAL 5: The State should explore expansion of in-home support services, and home health benefits should be expanded to allow individuals to maintain their own housing when, due to illness or physical disability, the individual requires more assistance.

DRAFT

CHAPTER 7

MANAGED MENTAL HEALTH CARE

BACKGROUND

Over the last few years, the orientation of health care has changed from the delivery of episodic treatment of illness to the planned provision of primary care and other necessary services in an integrated, coordinated system of service delivery. This coordinated system of care is known as managed care. Managed care, broadly stated, is a planned, comprehensive approach to providing health care that combines clinical services and administrative procedures within an integrated, coordinated system. This system is carefully constructed to provide timely access to care and services in a cost-effective manner. In a managed care system, individual providers are linked together under the umbrella of a single entity, the managed care plan. Managed care's emphasis on access to health care is intended to increase the utilization of primary care services whenever possible and thus reduce the unnecessary use of emergency rooms and inpatient services. Similarly, managed care's focus on mental health preventive services concentrates on promotion of a person's ability to function in the community (California Department of Mental Health, 1997a, page 18).

History of Mental Health Funding in California: the Short-Doyle Program

In 1957, state legislation created the Short-Doyle program, which established a county-based delivery system for mental health services. Initially, the program was voluntary, and each county was encouraged to start local community-based services. However, some counties did not take advantage of this opportunity to develop local services. To provide added incentive, the State implemented a matching formula and developed a 50-50 funding split, in which the State matched each county dollar expended. County participation was still slow in developing, so the State changed the formula to 75 percent from the State and 25 percent from the counties. The formula was changed once more to 90 percent state funds and 10 percent county funds, except for inpatient services, which were funded 85 percent state funds and 15 percent county funds in order to encourage counties to use less costly outpatient services. Eventually, the State required all counties to ensure delivery of mental health services.

Medi-Cal

In 1966, California enacted the Medicaid program, referred to as "Medi-Cal." This program allowed the State to receive federal financial participation to provide health care services, including mental health services, to eligible residents who were federal cash grant welfare recipients. These services, also known as Fee-for Service Medi-Cal (FFS/MC), were provided by a voluntary network of private providers throughout the State. For mental health services, those providers would be psychiatrists and psychologists. The rates for FFS/MC have been significantly less than providers' usual and customary beneficiaries.

Short-Doyle Medi-Cal

In 1971, the Short-Doyle/Medi-Cal (SD/MC) program was established. It allowed counties to obtain a 50 percent federal match on their costs of providing certain mental health services to persons eligible for Medi-Cal. At this point, the Medi-Cal program split into two mental health service delivery systems: the existing FFS/MC program continued mainly as a system of private providers, and the SD/MC program was established as a system of public providers, primarily county mental health programs and their contracted community agencies. As previously noted, the FFS/MC system was primarily solo practitioners in psychiatry and psychology whereas in the SD/MC program the services were provided in a clinic setting. Psychologists, social workers, marriage and family counselors, and other ancillary therapists who were under the auspices of a medical director of a clinic were able to provide a range of services to clients. The reason for establishing the SD/MC program was to allow for a wider variety of treatment options to adults with mental illness and children and youth with serious emotional disturbances than the office-based private practitioner of the FFS system was able to provide.

Equity of Mental Health Funding at the County Level

During the development of the Short-Doyle program in the late 1960's, some counties were aggressive in matching dollars and others were not. As a result, historical inequities in funding developed. These inequities were compounded when many counties did not pursue the 50 percent federal match for Short-Doyle/Medi-Cal either. As a result, those counties had far less resources for providing mental health services to the clients in

their communities. These inequities continue to present-day because the funding formula for realignment reflects the original matching formulas and each county's individual level of participation prior to the enactment of realignment.

Although the need to achieve equity in funding among California counties has been an issue of contention, no under-equity county has ever been able to catch up. These historical and persistent inequities affect the level of Medi-Cal funds per capita available for each California county as well. Some counties have very little Medi-Cal funding, and others have a great deal. The result is a patchwork quilt of uneven levels of funding and uneven access to services throughout the State. Prior to realignment, a plan to reallocate these dollars, either Short-Doyle or Medi-Cal, was never attempted because of the political ramifications of taking from one county to give to another.

California's "Managed" Mental Health Program

California has had to "manage" the provision of public mental health services for many years due to limited resources and defined target populations. The bulk of funding for public mental health services, which came from the State General Fund, was discretionary. Goodwin and Selix describe the decline in mental health funding:

> The current level of funding to mental health is estimated to be less than half that which is needed to provide a basic level of care for the existing mentally ill population. Beginning with an inadequate funding base, state allocations to counties were severely diminished due to inflation throughout the 1970s and 1980s, inadequate cost of living increases, and increasing population with increasingly serious problems. From 1982 to 1987, there were no cost-of-living increases or caseload adjustments to community mental health. In 1988, funds were reduced, and in 1989, an additional fifteen percent was reduced from the base funding for community mental health.
>
> In 1990, California faced a $14.3 billion shortfall. Community mental health programs were already near collapse and overwhelmed with unmet need. Advocates feared massive budget cuts to programs that could be irreparable. Significant policy and fiscal decisions regarding the future of community mental health programs had to be made quickly (Goodwin, 1998).

In 1991, in an effort to stop the continued assault on mental health funding, California enacted a law (Chapter 89, Statutes of 1991) providing that a portion of the sales tax and revenues collected from vehicle licensing fees would be used to establish a Local Revenue Fund. This fund is restricted to expenditures for county health, mental health, and social services. This realignment of funding from the State to the counties saved the mental health system from financial disaster by removing funding for mental health services from the discretionary State General Fund. Counties now could rely on a constant funding base from which to plan for the provision of mental health services. In addition, this law also established target populations for adults, children and youth, and older adults that specified the diagnoses and functional limitations necessary for a client to meet the target population definition, ensuring that those clients with the most severe mental illnesses received services.

The Move to Medi-Cal Mental Health Managed Care in California -- the "Carve-Out"

In step with the national trend, the Department of Health Services (DHS), which is the single state agency overseeing Medi-Cal, made a commitment to refocus the delivery of healthcare from episodic treatment for illness to the planned provision of services in a managed care model of service delivery. Following the policies of DHS, the Department of Mental Health (DMH) implemented a managed mental health care system for Medi-Cal services.

The DMH decided to "carve out" mental health care from the physical health care system into an individual managed care plan. In other words, public mental health services funded by Medi-Cal are separate from the physical health services managed care system. The DMH believes that carving out mental health care ensures that mental health services will be provided more appropriately and more effectively.

The Design of California's Managed Mental Health Medi-Cal Program

The design of managed mental health care for California's Medi-Cal program is based on statewide implementation of a single managed mental health plan (MHP) in each county (State of California,). The implementation of managed care with the county as the mental health plan is the logical extension of the state and county relationship. The counties are the primary sources of service to persons with mental illness and

emotional disturbance and have the ability to provide continuity of care for those periods when persons are not eligible for Medi-Cal but still require "safety net" services to maintain themselves in the community. Additionally, the counties are responsible for the provision of many high cost public services used by persons with mental illness, such as foster care, juvenile justice, indigent health care, and jail services.

The DMH operates under a "Freedom of Choice" waiver, under Section 1915(b) of the federal Social Security Act. This waiver, which is reviewed and approved by the Health Care Financing Administration (HCFA), allows California to limit a Medi-Cal beneficiary's choice of providers for mental health services as long as access and quality of services are ensured. This waiver is subject to review and must be renewed every two years.

In November 2000, HCFA approved the renewal of California's Medi-Cal Specialty Mental Health Services consolidation waiver program. The renewal is effective through November 19, 2002. HCFA placed several conditions on the waiver program, which include the following:

- The State must conduct an independent assessment of the program no later than August 2002;
- For the next renewal in 2002, the State will be required to justify the sole source exemption that allows the DMH to contract with counties to be mental health plans rather than using a competitive procurement process; and
- The State will be required to submit annual reports to HCFA about services to children with special health care needs. Children with special needs include children on Supplemental Security Income (SSI), children in foster care and adoption assistance programs, and other children with special physical health care needs.

Consolidation versus Capitation

California's mental health managed care system is not a capitated system in which MHPs would be paid a fixed amount for each beneficiary regardless of the amount or cost of services received by the beneficiary. Capitation would require the State to spread the full risk for provision of services to the MHPs. Spreading the risk evenly is problematic because of the great inequity in the historical base of allocation for both realignment funds and Medi-Cal dollars in the State. For this reason, the counties and State have begun to examine other ways to share risk that would still assure that the beneficiaries receive access to services and that providers, whether county-operated or contracted, do not go into bankruptcy.

California's Phase-In Approach to Implementation

California chose to phase in implementation in order to assure an orderly process. Implementation included two phases with the final phase of a pre-payment system to be implemented in the future when access and full risk management to the MHPs can be assured on a statewide basis.

Phase I: Consolidation of Psychiatric Inpatient Hospital Services

Consolidation under Phase I began in January 1995. Funds previously appropriated for DHS to pay for FFS/MC inpatient hospital mental health services were transferred to the MHPs, making the MHPs the single point of authorization and payment of Medi-Cal psychiatric inpatient hospital services. MHPs negotiate contract requirements and rates with inpatient hospital providers using state and federal law and regulations as minimum requirements.

Phase II: Consolidation of Specialty Mental Health Services

In addition to assuming the risk for inpatient hospital services, MHPs are assuming the risk and funding for Medi-Cal specialty mental health services, which include outpatient and service coordination. Consolidation of hospital and outpatient services results in one system of care with a single fixed point of responsibility and accountability, thereby maximizing the chances for beneficiaries to receive appropriate care.

Phase III: Implementation of a Pre-payment System

The DMH believes that the development of a pre-payment system must be based on extensive analysis of data of a particular population to be served. This in-depth financial analysis is crucial to achieve reliable information on costs for risk-based contracting. For this reason, the counties and State have begun to look at other ways to share risk and to assure that beneficiaries receive access to services, as well as assure that county-operated and contracted providers, remain financially viable. Types of alternative contracting include the following:

- Case Rate Contract. Under this model, contracted services are based on a type of group or population.
- Partial Capitation. Under this model, contracted services are based on the number of recipients expected to use a certain type of service.
- Capitation with Risk Corridor. This model incorporates a set-aside for costs exceeding the normal amount of risk. For example, a risk pool may be established in which a percentage of each premium goes into a fund; a provider may buy insurance to protect against catastrophic losses; or several counties might form a risk pool together.

CMHPC'S PRIORITIES

The California Mental Health Planning Council (CMHPC) chose its priorities for managed care by focusing on issues that would remain salient, as well as issues that other constituency groups were not already closely examining.

Meaningful involvement of clients and family members

The DMH has made a commitment to ensure that consumer and family involvement is an overriding value in planning, implementation, and oversight. Most significantly, the DMH established the Client and Family Member Task Force (CFMTF), consisting of clients and family members from around the State. The CFMTF has provided consultation and advice on all aspects of managed care implementation to the DMH and has been instrumental in establishing policy recommendations. The CFMTF has been an effective and accessible means of communication with policymakers in the mental health system and is now recognized widely for its broad involvement in statewide mental health initiatives.

Recommendation: All stakeholders should acknowledge that client and family member involvement is critical at both the state and local levels. All stakeholders must make a commitment to involve clients and family members at all levels of policy development by assuring funding for outreach, training, travel, and stipend money.

Recommendation: The DMH and MHPs should conduct both state-level and ongoing local-level training for clients and family members in order to develop a large pool of qualified clients and family members who understand the issues and can advise and advocate effectively.

Access to culturally competent services for beneficiaries

Access is the availability of appropriate services to people who need them in a manner that facilitates their use. The implementation plans require MHPs to ensure that mental health services are geographically accessible; available for special populations; and available 24-hours a day for urgent conditions. Beneficiaries living out of the county must also be provided access to mental health services.

Welfare and Institutions Code Section 14684 requires the delivery of culturally competent and age appropriate services to the extent feasible. This standard includes providing information in the appropriate languages and providing information to persons with visual and hearing impairments. MHPs are required to set goals to achieve cultural and linguistic competency under consolidation of specialty mental health services. MHPs are required to perform a population assessment as well as an organizational and service provider assessment to provide a readiness check for appropriate access.

Recommendation: All stakeholders must encourage efforts to address diversity at all levels of the system and advocate to assure equitable access and services that are culturally appropriate.

Grievance procedures and rights of beneficiaries

MHPs must comply with the requirements of the implementation plans. Client access to appropriate, culturally competent, coordinated services is the responsibility of the MHP. Clients should also be satisfied with the services they receive. Ideally, MHP's should assist consumers and family members in navigating the mental health system, including assistance through the complaint and grievance processes. A description of these processes is included in the regulations governing specialty mental health services (Title IX, Chapter 11 of the California Code of Regulations). Included in these regulations are requirements that counties provide written information to clients about grievance procedures. However, a constant concern of clients and advocates is the inconsistency with which this information is made available in each county.

Recommendation: The State Department of Mental Health should develop standards regarding grievance and appeal rights for a brochure that all MHPs would be required to use. All stakeholders need to continue to develop easily understood, consumer-friendly documents that are clear about procedures for identification and resolution of complaints and grievances, and information sources at both the state and local levels. Training and education should be provided at all levels of the mental health system so the system is user-friendly.

Adequacy of interface between health and mental health services

The interface with physical health care is a major concern of the CMHPC. How clients are referred between the systems; training of both physical health care and mental health care staff; clinical consultation, especially regarding medications; and the exchange of confidential client information must be carefully planned so that clients are assured of receiving all of the services to which they are entitled. Many adults, children, and youth served by the mental health system have concurrent serious physical health problems. In addition, laboratory work is necessary with certain medications. When psychiatric hospitalization occurs, medical histories must be taken and physicals performed. At times, when hospitalization for a medical problem occurs, a psychiatric consultation must be performed. All of these issues need to be clarified in terms of payment and responsibility.

Minimum Standards between Managed Care Plans and Mental Health Plans

The development of a written agreement that addresses the issues of interface in the delivery of Medi-Cal covered services to beneficiaries who are served by both parties is a shared responsibility between the counties' physical health managed care plans (MCPs) and the MHPs. These two entities are required to execute a memorandum of understanding (MOU) that specifies the respective responsibilities of the MCP and MHP in delivering medically necessary Medi-Cal covered physical health care services and specialty mental health services to beneficiaries. The DHS has issued a policy letter to the MCPs to provide a guideline for this responsibility.

Mental Health Training of Primary Care Physicians

Primary care physicians have enough information and training to detect, screen, and diagnose a mental illness and then to decide if he or she can appropriately treat the client or if the client should be referred to the mental health system. The medical community is addressing the need for training. In 1998, the California Medical Association adopted a resolution to collaborate with other organizations to provide mental health training for primary care physicians (California Medical Association, 1998).

Recommendation: MHPs should ensure that ongoing collaboration and communication with primary care physicians occurs.

Access to the Most Appropriate Medications

When MHPs assumed responsibility for specialty mental health services through the carve-out, the provision of pharmacy services remained with the physical health managed care plans. MCPs expressed concerns about the expense of these new, innovative antipsychotic medications. The amount of money allocated for pharmacy services in the MCPs is fixed, which could provide a disincentive to prescribe the newer, more costly medications. Mental health advocates feared that clients would not be prescribed the newer medications because their cost would become prohibitive to the MCPs. This concern prompted the DMH to establish an agreement with DHS that most antipsychotic medication pharmacy benefits for mental health clients would be carved out of the MCPs and billed through fee-for-service Medi-Cal.

Recommendation: The DHS and the DMH should continue to find ways to assure that the most efficacious medications to treat mental illness are prescribed to clients regardless of cost.

Risk-based Contracting

Risk-based contracting and its alternatives described previously will provide MHPs the flexibility to create or contract for services that will be most appropriate and most cost-effective for their clients. However, no actuarial data for serious mentally ill populations are available from which to establish risk-based contracting. Providers that enter into risk-based contracting should be assured that they will receive the right volume of clients to balance out the risk. These data will be critical as the DMH begins implementation of a pre-payment system in Phase III.

Recommendation: The DMH should convene a task force of mental health professionals, actuaries, insurance industry representatives, and managed care providers to determine the assumptions upon which to base the mental health managed care system design. Furthermore, those assumptions must be tested so that a basis for risk can be established to obtain more definite information on costs. This discussion should include how changing populations will change risk factors.

Oversight by the Department of Mental Health

The State has developed an oversight system that involves on-site reviews of each MHP. Review teams include county peer reviewers, direct consumers, family members, and DMH staff. These teams identify problems and then DMH issues plans of correction to the MHPs. The DMH then monitors the MHP as it makes these corrections. In addition, to address statewide issues of system accountability and quality improvement, the DMH has established a Quality Improvement Committee, consisting of representatives from stakeholder organizations.

The CMHPC has the responsibility to ensure that the DMH is providing adequate oversight of the Medi-Cal managed care system. Discussion and recommendations regarding system accountability and oversight are in Chapter 7.

CHAPTER 8

SYSTEM ACCOUNTABILITY AND OVERSIGHT

CALIFORNIA'S PUBLIC MENTAL HEALTH SYSTEM

California's public mental health system provides mental health services to persons with serious mental illnesses who have no recourse to services in the private health care sector. Most public mental health clients, through either poverty or the degree of disability caused by their mental illness, qualify for Medi-Cal and receive public services through that funding source. Annually, the mental health system serves over 360,000 clients as shown in Table 6 below. Approximately three-fourths of the clients are adults, and one-quarter are children. Approximately 1 percent of the State's population received services from the public mental health system in fiscal year 1996-97.

Table 6 classifies clients according to the type of services they receive. Brief services are a modality in which a client receives services for a limited time, usually less than 60 days, to resolve a situational problem, such as grief from a loss, minor depression, or anxiety from family disputes. Long-term services are provided to adults with serious mental illnesses (SMI) and children with serious emotional disturbances (SED) who have persistent mental health problems requiring services for a period longer than 60 days.

Table 6: Clients Served by the Public Mental Health System in Fiscal Year 1996-97

Client Type	Children (0-17)	Adults (18+)	Total
Brief Services	71,900	80,700	152,600
SMI/SED (long-term)	24,400	184,300	208,700
Total	96,300	265,000	361,300
State Population	9,456,000	24,408,000	33,364,000

Table 7, which provides the breakdown of clients' diagnoses for fiscal year 1994-95, reveals the serious nature of the mental illnesses treated by the mental health system. Schizophrenia and other psychoses comprise 25 percent of the diagnoses; bipolar disorder, 8 percent; and depressive disorders, 22 percent. These disorders typically require life-long management, frequently with the continuous use of medications. The diagnoses of children in the mental health system are typically childhood disorders and adjustment disorders, which together account for approximately 20 percent of the diagnoses.

Table 7: Diagnoses of Clients in the Public Mental Health System in Fiscal Year 1994-95

Diagnosis	Percent
Schizophrenia	13.2
Other Psychoses	11.5
Bipolar Disorder	7.9
Depressive Disorders	22.3
Substance Abuse	5.8
Other Nonpsychotic	9.8
Childhood Disorders	9.7
Adjustment Disorders	10.7
Cognitive Disorders	1.5
Unknown	7.6

Because of the ethnic diversity in California, the public mental health system must meet the needs of a very diverse population. As Table 8 illustrates, over half the clients served in the mental health system in fiscal year 1996-97 were White; nearly 19 percent, Hispanic; 16 percent, African American; and approximately 6 percent from various Asian ethnic groups. Because the concept of mental illness and traditional treatments vary among cultures, providing culturally competent services to clients of such diverse ethnic backgrounds is a major challenge for the mental health system. Even more difficult is meeting the needs of monolingual clients.

DRAFT

Table 8: Ethnicity of Clients in the Public Mental Health System in Fiscal Year 1996-97

Race	Percent
White	53.7
Hispanic	18.7
African American	16.0
Native American	0.9
Asian/Pacific Islander	2.1
Southeast Asian	2.9
Filipino	0.9
Other/Unknown	4.8

Table 9, which presents expenditures for fiscal year 1996-97, reveals the vast undertaking of providing public mental health services in this State. Over $1.7 billion was spent in fiscal year 1996-97 providing public mental health services. Approximately $450 million was spent for children, and $1.25 billion was spent for adults. Most of these funds, $1.6 billion, are spent by county mental health programs providing mental health services in their communities.

Table 9: Expenditures in the Public Mental Health System for Fiscal Year 1996-97 (in millions)[4]

Services	Children	Adults	Total
Community Mental Health (includes Acute Inpatient)	$438.8	$1,151.1	$1,589.9
State Hospitals (Civil Commitments Only)		99.9	113.1
Total	$452.0	$1,252.0	$1,702.0

EVOLUTION OF OVERSIGHT OF THE PUBLIC MENTAL HEALTH SYSTEM

Because of the magnitude of public expenditure, the serious nature of the mental illnesses, and the need of mental health clients for on-going treatment and rehabilitation, the State Legislature, at the urging of the mental health advocates and providers of services, adopted a requirement that county mental health programs must collect and report to the Department of Mental Health (DMH) data on the performance of their mental health systems.

In 1991, the Legislature enacted a statute that realigned the funding and program responsibility for mental health services. Previously, the mental health system had been funded from general tax revenues. Because mental health services were not an entitlement, they fared poorly in the State's annual budget process. During the 1980's, the mental health system experienced serious erosion of its funding by not being able to keep up with inflation. It even experienced reductions in state funding during that period. Because of the system's serious fiscal problems, the mental health community was open to changing the funding strategy. The realignment legislation replaced the General Fund revenues with one-quarter cent of the Sales Tax, which was dedicated to county mental health services.

Because sales tax revenues are considered a local revenue source, this funding arrangement dramatically changed the governance of the public mental health system. Prior to realignment, the system had been centralized under the control of the DMH, which allocated funds to county mental health programs and directed the types of services to be provided. After realignment, the DMH's role was more one of providing technical assistance to local programs, managing the state hospitals, and administering the State's Medi-Cal program funding mental health services.

During the development of the realignment legislation, mental health advocates were concerned about the loss of centralized authority over the county mental health program. Realignment gave counties greater autonomy to design their own service systems and greater flexibility in how they spent the funds. Advocates wanted to

[4] These expenditures exclude the cost of services provided to patients who are judicially committed to state hospitals

ensure that a system was in place that held counties accountable for results of their management of local programs. As a result, the realignment legislation included a requirement that county mental health programs had to collect and report to the State performance outcome data on their clients.

Several years after the enactment of realignment and its performance outcome measure requirements, the DMH initiated a major system change: consolidating the Fee-for-Service Medi-Cal system with the Short-Doyle Medi-Cal system and moving the entire Medi-Cal mental health system to managed care. Chapter 6 on Managed Mental Health Care describes the evolution of this system. The managed care initiative necessitated that the DMH rethink its approach to oversight of the public mental health system. It issued a series of papers on oversight (California Department of Mental Health, 1998c);(California Department of Mental Health, 1998b).

Requirement To Collect Performance Outcome Data

In the realignment legislation, the DMH was given the responsibility to establish a committee that would specify the outcome measures. In subsequent legislation, the California Mental Health Planning Council (CMHPC) was given the authority to review and approve all outcome measures and to use the data to review program performance annually. Additionally, the CMHPC is supposed to use the data to identify best practices in providing mental health services so that those services can be replicated in other counties. These statutory provisions are found in the Welfare and Institutions Code (WIC), Section 5772(c).

Mental health boards and commissions (MHBCs) are also given a role in the interpretation of their counties' performance outcome data. WIC Section 5604.2(a)(7) requires that MHBCs review and comment on the performance outcome data and communicate their findings to the CMHPC. The CMHPC developed a workbook format to facilitate this reporting process by MHBCs. Each MHBC received a workbook with that county's performance outcome data. The data were accompanied by a series of questions to assist the MHBC members in interpreting the results for each indicator. The workbook also contained additional demographic and socioeconomic data to assist the MHBCs in understanding the local context for its county's results. MHBCs were encouraged to collaborate with the local mental health program to complete the workbook. Once the CMHPC received all the workbooks, it prepared a statewide report, which by statute was distributed to the Legislature, the DMH, county governing bodies, and MHBCs. The CMHPC anticipates using a similar procedure with future performance outcome data.

The system to collect performance outcome data has evolved into a massive undertaking. Data are to be collected annually for all clients who receive services for more than 60 days. Table 1 shows that approximately 25,000 children and 185,000 adults and older adults fall into that category. This requirement was essentially created through the political process for developing legislation. Its implementation has been overseen by a collaboration of representatives from the CMHPC, the DMH, and county mental health programs. Implementation decisions have been guided by what the CMHPC believes is necessary for it to provide oversight of the system tempered by the need to have an administratively workable system that was not too burdensome on county mental health programs.

Theoretical Perspective on Use of Performance Indicators for Quality Assessment

Nature of Performance Indicators

Performance indicators are evaluative criteria (Sofaer, 1995). A set of indicators represents an explicit statement of expectation for the health care delivery system. Performance indicators are intended to provide useful information relevant to whether their expectations are being met. Donabedian (1980) identified three types of performance indicators: structure, process, and outcome. Structure relates to the prerequisites to providing services in systems of care, which include the administrative structure, fiscal organization, organization of programs, and interagency collaboration. Structure can often be evaluated by assessing compliance with specific requirements to operate the program (California Department of Mental Health, 1998c).

Process is the proper provision of services in systems of care. Process indicators include utilization of various types of services. Process is often evaluated through assessment of access and adherence to standards (California Department of Mental Health, 1998c). The third type of performance indicator is outcome. Outcome is the impact of care on health and well being, the ultimate goals of providing services. These goals include improvement or stabilization in a client's symptoms and functioning and in client satisfaction with quality of life, health status, and community integration (California Department of Mental Health, 1998c).

DRAFT

The DMH's oversight paper adopts the triad of performance indicators: structure, process, and outcomes. However, other researchers working on oversight of the public mental health system further subdivide process into access, appropriateness, and cost-effectiveness indicators. Access is the availability of culturally competent services to persons who need them in a manner that facilitates their use. Access includes the degree to which services are quickly and readily obtainable. It also relates to the availability of a wide array of relevant services to meet individual needs (Task Force on a Consumer-Oriented Mental Health Report Card, 1996).

Appropriate services are those that are individualized to address a consumer's strengths and weaknesses, cultural context, service preferences, and recovery goals. Appropriateness of care refers to the best possible match between client's needs and (a) level of care, e.g., inpatient or outpatient, and setting, e.g., psychiatric ward, office, home; (b) the chosen treatment or intervention, e.g., medication or therapy; and (c) service utilization, e.g., length of stay, number of outpatient sessions, and appropriate transitions. Standards for assessing appropriateness are based on the best available efficacy, effectiveness, appropriateness, and quality of care research (Salzer, 1997).

Cost effectiveness is the ability to use resources efficiently to achieve positive outcomes. An example would be using crisis stabilization or crisis residential services instead of acute inpatient hospitalization, if appropriate to a client's needs.

Recommendation: The CMHPC recommends that the following taxonomy be used in classifying the performance indicators for oversight of the public mental health system:

1. Structure
2. Process
    a. Access
    b. Appropriateness
    c. Cost-effectiveness
3. Outcomes

Definitions

One of the issues that the DMH highlighted in its first paper on oversight of the public mental health system was the need for consistent terminology when discussing performance outcome issues:

> …terminology has been and continues to be a major stumbling block in discussions of oversight. It is the practice in both the private and public sectors to use terms like "indicator," "outcome," and "standard" routinely, and yet specific meanings vary according to the context in which each is used. A common language needs to be developed to facilitate communication of principles and practice regarding oversight (California Department of Mental Health, 1998c).

The American College of Mental Health Administration (ACMHA), a national organization of mental health clinicians and administrators, has undertaken a project to develop a proposed set of performance indicators that can be used by both public and private behavioral health care providers. As a part of this project, it has developed a taxonomy of terms related to performance indicators:

- Domain: the most global term, which would be at the level of structure, process, access, appropriateness, cost effectiveness, and outcome.
- Concern: the most salient issue to be addressed by measurement strategies; describes the desired goal of service provision; e.g., "Clients can access services that they need" states a "concern."
- Indicator: something being measured
- Measure: the mechanism or data element identified to support a judgement or an indicator.

Characteristics of Valid Performance Indicator Sets

The process for developing and adopting performance indicators must have normative validity (Sofaer, 1995). When performance indicators have normative validity, all stakeholders would agree that the indicators reflect

their shared values about the ideal nature of the mental health system. Selection of performance indicators is inherently value-laden. Different constituency groups bring different norms, values, and priorities to bear on the inclusion of particular indicators and the construction of indicator sets. The statutory role given to the CMHPC to approve performance outcome measures assures normative validity because its membership includes all key stakeholders:

- direct consumers;
- family members;
- advocates;
- local mental health directors;
- community agencies;
- mental health professionals; and
- state agencies, including the DMH.

A performance indicator must be an effective proxy for critical aspects of provider, health plan, or health care system functioning (Sofaer, 1995). Performance indicators operationalize evaluative criteria. Each indicator should be a valid and reliable measure that is both sensitive and specific. Indicators should be also effective in distinguishing high and low performers.

Selected indicators should carry a great deal of information on important issues. Indicators should be chosen not only because they measure attributes that are important in themselves but also because these attributes correlate highly with other important characteristics. Identifying good proxies for system performance requires understanding the relationships between and among health care structures, process, and outcomes. A good performance indicator should be backed by empirical evidence of these relationships.

Performance indicators should also possess criterion-related validity (Salzer, 1997). Criterion-related validity is "the degree to which services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Institute of Medicine, 1991, page 1). Criterion-related validity pertains to the extent that structure and process indicators are linked with outcome and outcome indicators are linked to structure and process.

Inferences about the validity of a performance indicator can be drawn from the types of evidence listed below. Stronger inferences can be drawn from methods at the head of the list; weaker inferences from those methods near the end of the list:

- meta-analyses;
- randomized clinical trials;
- nonrandomized clinical trails;
- expert panel judgement; and
- individual practitioner judgement.

The majority of indicators in contemporary efforts to develop indicator sets are based on expert opinion. Salzer (1997) explains that indicators based on expert opinion have normative validity:

> …normative and consensual validity are weak forms of evidence for making conclusions about criterion-related validity…. This is a reasonable place to begin given the current dismal state of quality of care research, but it must be emphasized that these are unvalidated indicators. Care must be used when discussing results using indicators based on weak forms of inferential evidence (p. 299).

Performance indicators can be referred to as valid when the link between structure, process, and outcome has been established. This approach holds service providers accountable for developing quality service structures and processes that can be expected to produce positive outcomes. This approach is more appropriate than holding service providers responsible for poor outcomes that may have resulted despite high-quality service delivery. The value of a proposed structure or process indicator as a measure of quality is determined by the extent to which it is related to some outcome (Salzer, 1997). For example, coordination of services, a structural variable, may be found to be associated significantly with decreased symptoms and increased functioning. Coordination of services would then be viewed as a valid indicator of decreased symptoms and increased functioning.

DRAFT

Figure 2 illustrates the relationships between indicators of structure and process and those of outcome. Salzer's point is that the causal relationships between aspects of the service system and outcomes must be established in order to consider indicators that measure characteristics of the service system to be valid indicators of quality. Similarly, outcomes that are not a result of the delivery of mental health care cannot be considered valid performance indicators.

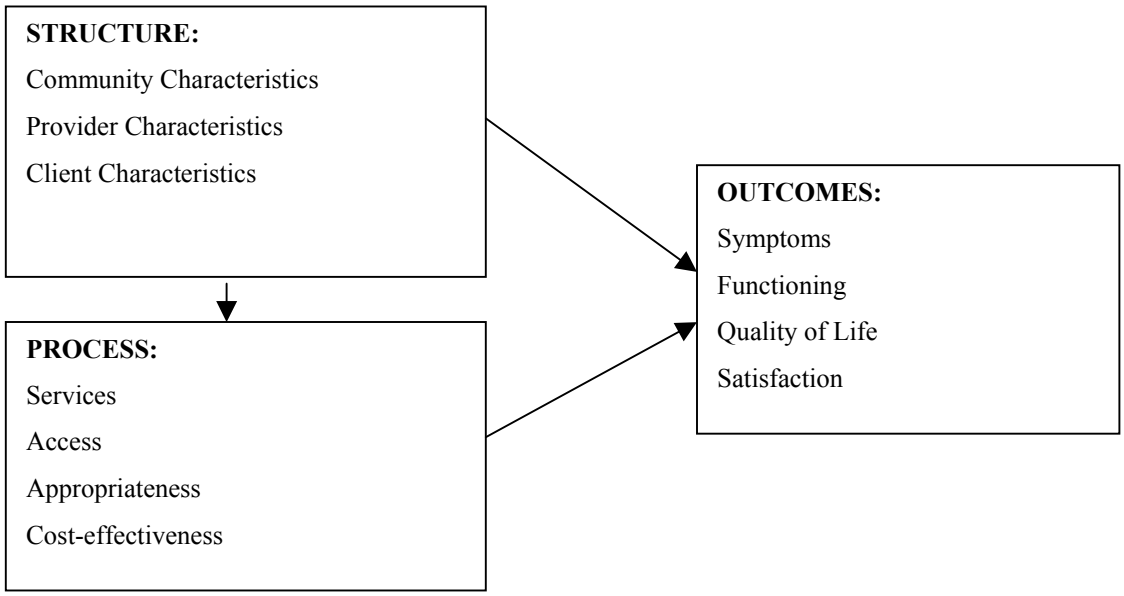

Figure 2: Model of Relationships among Performance Indicators

Theoretically, all the elements in the structure and process parts of the model can affect outcomes. For example, variables related to structure could include the county's unemployment rate, the amount of mental health funding per capita, and the case mix of clients served as measured by severity of their mental illness. Each of these factors can influence both the process of providing services and the outcomes. A county with higher per capita funding will be able to offer a more complete array of mental health services and more units of service. An outcome, such as the rate of employment of clients, will be affected by the unemployment in the county. Counties with adverse economic conditions are going to have a harder time placing clients in paid employment than a county with many job opportunities. A client's level of functioning is also going to determine the extent to which he or she can participate in paid employment. This basic example with one performance indicator, rate of client employment, illustrates the complex set of factors that contributes to producing an outcome.

The Appendix to this chapter contains an example of indicator sets for each target population. Indicators are included for each type of indicator discussed in the theoretical model: structure, process (access, appropriateness, cost-effectiveness), and outcomes.

NEED FOR AN INTEGRATED DATA SET FOR OVERSIGHT

An integrated data set is needed to validate the relationships among the structure, process, and outcome indicators and to evaluate the performance of local mental health programs. "Integrated data sets" refers to the ability to link a variety of information about clients across the DMH's separate data systems. The following data systems are available for system oversight:

- Client and Services Information System
- Cost Reporting/Data Collection System
- Performance Outcome Indicators
  - Children and Youth

DRAFT

  - Adult
  - Older Adult
- Children's System of Care data elements
- Medi-Cal Paid Claims
- Managed Care Implementation Plans
- Cultural Competency Plans
- Onsite Reviews

Chapter 738, Statutes of 1998, (SB 2098, Wright), required the DMH to develop unique client identifiers for its data systems. These identifiers will mean that demographic, service utilization, cost, and performance indicator data for each client can be linked across data sets. This capability will enable the DMH to conduct studies to determine the criterion-related validity of the performance indicators. Generally, data are available from the DMH's data system 6 to 12 months after the close of the fiscal year.

CONCEPT OF ACCOUNTABILITY

The main purpose for creating performance indicators was to facilitate oversight of county mental health programs by the DMH, the CMHPC, and local mental health boards and commissions. The intention was also that local mental health programs could monitor their own performance and use the data in their quality improvement processes.

Although performance indicators hold great promise in helping to improve the quality of mental health programs, users of the data must be mindful of their methodological limitations. Much work needs to be done before unambiguous conclusions can be drawn from performance indicators. For example, measurement error and confounding variables affect the kinds of outcomes counties can report. These factors have no relationship to the quality of the services provided. Some of these limitations in interpreting performance outcome data were identified in the first attempts to analyze the data in the early 1990's. For example, the first analyses of the adult performance outcome data, which were collected in fiscal year 1992-93, ranked counties from the best to the worst outcomes on various indicators. However, a cursory analysis revealed the flaw of that approach: some outcome measures are strongly influenced by local conditions. For example, counties with the lowest rate of employment for consumers also had the highest rates of unemployment for their general populations.

These data must be interpreted within their local context taking into account client characteristics, socio-economic conditions, and resources. Risk adjustment is the process for adjusting performance indicators so comparisons among counties can be made. Without such adjustments that take into account differences among counties, direct comparison of counties' results is not possible. Until techniques for risk adjustment are developed, the CMHPC needs to use a different approach for accountability. That approach is to hold counties accountable for their use of the data in their quality improvement processes. Counties can demonstrate their accountability by using performance indictor data in their quality improvement processes. Performance indicator results can be used for a variety of purposes:

- identifying gaps in the system of care;
- improving the quality of existing services; and
- identifying opportunities for great efficiency and more cost-effective services.

Recommendation: Because the performance indicators lack established criterion-related validity, risk adjustment to compensate for differences among counties, and benchmarks for minimum acceptable performance, the data must be used to describe the performance of the current system. System development should focus on the following actions:

- assure that the indicator set has face validity and normative validity;
- generate data for each county from existing data systems for the indicators, which will stimulate productive discussions about their implications related to the quality of the service system;
- use local quality improvement systems to explore the relationships between the indicators and to understand variables that influence quality; and
- encourage scientific studies to establish the criterion-based validity of the indicator set.

DRAFT

ROLE OF CMHPC IN SYSTEM OVERSIGHT

Section 5772 of the Welfare and Institutions Code (WIC) gives the CMHPC the authority to review, assess, and make recommendations regarding all components of California's mental health system. The statute makes frequent reference to the term, "performance outcome measure," in describing the CMHPC's mandate. The statute was developed in the early 1990's. Only in the last few years has the public sector integrated the increased theoretical sophistication of oversight and quality review from the behavioral health care industry and the research literature. The term, "performance outcome measure," has come to refer to one type of performance indicator that measures the results of receiving services on a client's health and well being. In using the term, "performance outcome measure," the authors of the legislation were referring to the broader class of indicators now understood to include structure and process indicators. Specifically, data recommended to be collected in WIC Section 5612 relates to both structure and process as the examples below illustrate:

- number of persons in identified target populations served relates to access;
- treatment plan development for members of the target population relates to appropriateness;
- percentage of resources used to serve children and older adults relates to access;
- number of patients' rights advocates and their duties relates to structure; and
- quality assurance activities relate to structure.

Recommendations:

1. In keeping with the intention of the statute, references in statute to "performance outcome measures" should be interpreted to mean "performance indicators." The CMHPC should assert its authority to approve all the performance indicators, not just the outcome indicators.
2. The CMHPC should continue to consult with the DMH on the development and implementation of current initiatives:
    a. managed care;
    b. performance outcome measures;
    c. the State Quality Improvement Committee; and
    d. the Compliance Advisory Committee.
3. The CMHPC should monitor the DMH oversight activities, including:
    a. assuring client and family member involvement in oversight activities;
    b. reviewing and commenting on various oversight protocols and procedures; and
    c. assuring that plans of correction from onsite reviews are followed up on.
4. The CMHPC should assist MHBCs with their oversight responsibilities, including:
    a. determining how to assure that MHBCs are involved in the local quality improvement system; and
    b. determining how to help MHBCs assess the adequacy of local quality improvement systems.
5. The CMHPC should ascertain whether local mental health programs are using available data for quality improvement.

ROLE OF MENTAL HEALTH BOARDS AND COMMISSIONS IN SYSTEM OVERSIGHT

MHBCs have an important role to play in system oversight and accountability. Section 5604.2 of the Welfare and Institutions Code authorizes MHBCs to engage in various oversight activities, such as evaluating the community's mental health needs, services, and facilities; advising the governing body and the local mental health director about the local mental health program; and submitting an annual report to the governing body on the needs and performance of the county's mental health system.

MHBCs are essential partners of the CMHPC in the process of using performance indicator data for system oversight. Particularly relevant is Section 5604.2 (a)(7), which requires that the mental health board review and comment on the county's performance indicator data and communicate its findings to the CMHPC. Because understanding the local context is so central to understanding the performance of a county mental health

program, MHBCs have a very important role to play in process of using performance indicator data to evaluate local programs.

Recommendations:

1. The CMHPC should provide performance indicator data to MHBCs along with material to assist them in understanding and interpreting the data.
2. The CMHPC should also provide a consistent statewide format that MHBCs should use to report their findings to the CMHPC.
3. The CMHPC should use the reports from the MHBCs along with its own analysis of the results to prepare reports to the Legislature, the Department of Mental Health, and other stakeholders about the performance of the public mental health system.

PRINCIPLES TO GUIDE CONTINUED DEVELOPMENT OF OVERSIGHT AND USE OF DATA

The DMH, the CMHPC, and local mental health programs should adopt the following principles to guide development of oversight and the use of performance indicators:

1. Consumers and family members should be involved in development and implementation of oversight. This involvement can be ensured through the following means:
   - ♦ CMHPC representation on policy development committees;
   - ♦ continued involvement of the Client and Family Member Task Force; and
   - ♦ client and family member representation on on-site reviews.
2. To the extent possible, the oversight paradigm and performance indicators should be derived from accepted national models:
   - ♦ American College of Mental Health Administration; and
   - ♦ Mental Health Statistics Improvement Project Consumer Oriented Report Card.
3. All indicators should be derived from existing data. Very rich data sets have been created for the public mental health system. Stakeholders should master the use and interpretation of these data before developing additional requirements.
4. Performance indicators should provide data that are useful to the clinician in assessment and treatment planning and should enable the clinician to assess his or her own effectiveness.
5. When using the data, the DMH and the CMHPC should take an incremental approach to reporting the data. The goal of reporting results for performance indicators is to enable local mental health programs, mental health boards and commissions, and the CMHPC to understand the implications of the data analysis for system performance and improvement. Providing focused reports on aspects of performance rather than comprehensive reports on the entire system will likely result in better use of the data.
6. Different degrees of oversight are warranted for various populations being served. The amount of effort to evaluate services should be commensurate with the amount of resources spent providing services. For example, services to target populations should receive the most scrutiny. Services to brief and episodic users do not warrant as many resources for oversight.
7. To assure the cultural competency of oversight activities, the DMH should place high priority on developing proper translations of outcome instruments, obtaining sufficient back translations to produce valid instruments.

NEXT STEPS IN THE USE OF PERFORMANCE INDICATORS FOR SYSTEM OVERSIGHT

Risk Adjustment

Outcome indicators are influenced by many factors beyond the control of local mental health programs. The purpose of risk adjustment is to isolate the aspects of providing mental health services that are under the control of local mental health programs. To understand the performance of local mental health programs, the effects of those confounding variables beyond the control of mental health programs must be eliminated. This statistical

process is referred to as risk adjustment. Examples of variables to be used for risk adjustment include client characteristics, socioeconomic conditions in each county, and fiscal resources available to fund mental health services. Risk adjustment should facilitate the identification of best practices in the provision of mental health services.

At this point, risk adjustment techniques are highly theoretical and experimental. However, the field of risk adjustment is becoming better defined. For example, payors in the private behavioral health care field are using risk adjustment in provider profiling. Some state governments are using risk-adjusted performance indicators to make decisions about whether to fund specific mental health providers. Key principles for selecting risk adjustment variables are being proposed (Boaz, 1999);(Hendryx, 1999):

- they should be prognostic indicators of disease course;
- they should be substantively related to the outcome;
- they should be outside the control of providers to effect through treatment;
- they should be able to be measured reliably and validly;
- they should account for variance in the outcome indicator (dependent variable); and
- they should not interact with the provider groups, i.e., the relationships between risk adjustment variables and dependent variables are consistent across the providers.

Once the correct risk adjustment variables have been selected for each performance indicator and their effects on the indicators thoroughly analyzed, the data for each county should be adjusted to the statewide average for the risk adjustment variable under consideration. As risk adjustment analyses become more sophisticated, multivariate risk adjustment techniques should be used so that performance indicators can be adjusted simultaneously for more than one variable.

Recommendations: The DMH, CMHPC, and California Mental Health Directors Association (CMHDA) need to begin the process of developing risk-adjustment techniques so that the performance of local mental health programs can be compared to the statewide and regional averages.

1. A thorough literature review needs to be conducted to identify the independent variables besides mental health treatment that can affect each performance indicator.
2. The State's data bases need to be evaluated to determine whether they contain data on the relevant risk adjustment variables.
3. Data analyses need to be conducted to select the best risk adjustment variables for each outcome measure.
4. County mental health programs need to be involved in the selection and testing of risk adjustment variables to ensure that all the relevant factors that affect their performance are taken into account.
5. Once the risk adjustment variables have been selected and evaluated, each county's outcome data for each indicator need to be risk adjusted to the statewide average to facilitate comparisons with the statewide average and regional averages.

Decision Rules for Evaluating Performance

Risk adjustment is designed to eliminate differences among counties that cannot be attributed to delivery of mental health services. Once that step has been completed, the next logical step is to develop decision rules to identify high and low performers (Kamis-Gould, 1996). Comparing results of counties on an indicator to determine which is higher and which is lower is relatively easy. However, whether demonstrated variance means high performance or only a minor difference is not as self-evident. Because behaviors and performance levels vary and fluctuate over time, existing data must be analyzed to decide whether high levels will be determined by quartiles, percentiles, or better yet, standard deviations above and below the mean.

This approach for developing decision rules advocated by Kamis-Gould (1996) is consistent with the DMH's advocacy in its oversight white paper for "fenceposts" or "parameters" for indicators (California Department of Mental Health, 1998c). A multidimensional system of performance indicators requires decision rules that possess the following features:

- determination of high and low performance on any one indicator (e.g., in terms of standard deviations from the mean);
- determination of high and low performance on any one domain (e.g., at least two high performance indicators and no low one);
- a decision about whether stability over time should be built-in (i.e., whether some levels should be demonstrated more than once); and
- integration of levels across domains and determination of highs and lows on total performance.

Kamis-Gould (1996) provides the following example of decision rules used in New Jersey. New Jersey defines high performance as two standard deviations above the means on at least two performance indicators in at least two domains for two consecutive quarters and no low performance on any one domain. This standard is designed to exclude one-time spikes in performance and to keep highly efficient but ineffective providers from being considered high performers.

Recommendation: Once the DMH can reliably risk adjust the performance indicators, decision rules should be established to identify high and low performers.

DRAFT

APPENDIX

INDICATORS FOR SYSTEM OVERSIGHT FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCES[5]

CONTEXT, RISK ADJUSTMENT, OR CASE MIX VARIABLES[6]

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Differences among counties		
Concern: Differences among counties in resources, socioeconomic conditions, demographics, and client characteristics must be considered before any comparisons of performance indicator results can be made.	**Risk Adjust. 1:** County poverty rate.	Statistical Abstract
	Risk Adjust. 2: Per capita funding for mental health services for children age 0-17.	DMH and County Fiscal Systems
	Risk Adjust. 3: Degree of ethnic diversity in county population.	DOF Population Data
	Risk Adjust. 4: Severity of mental illness among client population age 0-17.	CAFAS or CBCL at intake

[5] The intention of the CMHPC is to recommend measures for which data are available. Because the set of instruments for collecting data in the children's system of care is in transition, data sources have not been specified for some measures. Modifications will have to be made to these proposed measures once new instruments are selected.

[6] These variables are being introduced for purposes of discussion only.

DRAFT

DOMAIN: STRUCTURE

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Staffing		
Concern: Staffing levels and training are appropriate for delivery of the array of services and provide for meeting the diverse needs of the individuals served, including linguistic and cultural competency	**Structure 1:** Number of staff per 1,000 clients by personnel classification.	County administration
	Structure 2: Percentage of staff who are bicultural by ethnicity.	County administration Cultural Competency Plans
	Structure 3: Percentage of staff who are bilingual by language.	County administration Cultural Competency Plans
Continuity of Care		
Concern: The organization has a single, fixed point of responsibility for children and families and provides continuity of care.	**Structure 4:** Under consideration.	None identified
Coordination of Care		
Concern: The organization provides effective linkages to other service systems with which children and families need to interact.	**Structure 5:** Under consideration.	Available only for physical health care from on-site review process
Quality Improvement		
Concern: The organization uses a quality improvement approach to monitoring the performance of its system of care.	**Structure 6:** The organization has a quality improvement system in place.	On-site reviews
	Structure 7: Counties are measuring children's performance outcomes and submitting the data to the DMH in a timely fashion.	DMH Performance Outcome Data System
Rights and Complaint Resolution		
Concern: Consumer rights are clearly defined and procedures for resolution of complaints and grievances are in place and easy to use.	**Structure 8:** Number of formal grievances filed by consumers.	Not collected

DRAFT

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
	Structure 9: Number of fair hearings filed by consumers.	DMH Ombudsman Office

DOMAIN: ACCESS

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Services Are Reaching the Intended Population		
Concern: Penetration rates demonstrate that services are reaching the intended populations, including culturally and linguistically diverse populations.	**Access 1:** Percentage of county population age 0-17 who receive mental health services in one year by modes of service as defined by Client Services and Information System (CSIS), gender, ethnicity, and diagnosis.	CSIS
	Access 2: Percentage of the county's monthly average Medi-Cal eligibles age 0-17 who receive mental health services in one year for all aid codes by modes of service, gender, ethnicity, and diagnosis.	Medi-Cal Paid Claims
Range of Service Options Available		
Concern: Children and families can access services that they need.	**Access 3:** Total units of service for each mode of service.	CSIS
	Access 4: Percentage of resources expended on mental health services provided in the field (natural setting, such as home, school, and work).	CSIS & CR/DC
	Access 5: Percentage of respondents who report that services they need are readily available.	CSQ-8 Q2, 3
Cultural and Linguistic Access		
Concern: Children and families have access to a mental health provider who meets their needs in terms of ethnicity, language, and culture.	**Access 6:** Percentage of new clients who do not receive a second service within six months of entry in the CSIS reported by ethnicity and language.	CSIS

DRAFT

DOMAIN: APPROPRIATENESS

INDICATORS FOR CHILDREN		MEASURES		DATA SOURCE
Voluntary Participation in Services				
Concern:	Children using mental health services do so voluntarily and in collaboration with their families and service providers. The use of involuntary mental health intervention is minimized.	**Appro 1:**	Percentage of admissions for psychiatric inpatient treatment that are involuntary.	CSIS
Services that Maximize Continuity of Care				
Concern:	The mental health provider or system maximizes continuity of care.	**Appro 2:**	Percentage of children discharged from inpatient services that receive ambulatory services within 7 days.	CSIS
		Appro 3:	Percentage of children in acute psychiatric inpatient care who have a visit from a case manager while in the hospital.	CSIS, but could be difficult to obtain
Minimal Recurrence of Problems				
Concern:	Children experiencing an episode of acute psychiatric illness receive care that reduced the likelihood of a recurrence within a short period of time.	**Appro 4:**	Percentage of inpatient readmissions that occur within 30 days of discharge.	CSIS
Family and Youth Involvement in Policy Development, Planning, and Quality Assurance Activities				
Concern:	Families and youth using mental health services have meaningful involvement in program policy, planning, evaluation, quality assurance, and service delivery.	**Appro 5:**	Percentage of full-time equivalent staff positions that are occupied by family members of children who have received public mental health services.	Special Studies
		Appro 6:	Percentage of youth on mental health boards and commissions and Quality Improvement Committees.	Special Studies
		Appro 7:	Percentage of family members on mental health boards and commissions and Quality Improvement Committees.	Special Studies

DRAFT

DOMAIN: COST EFFECTIVENESS

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Scarce Resources Expended Efficiently		
Concern: Use of most restrictive and most costly services is minimized to the extent feasible.	**CE 1:** Proportion of total expenditures for services spent on placements in ♦ state hospitals ♦ group homes ♦ foster homes ♦ acute psychiatric hospitals	Various state data systems collected for system of care counties
	CE 2: Number of placements in ♦ state hospitals ♦ group homes ♦ foster homes	Various state data systems collected for system of care counties
	CE 3: Length of stay in state hospitals for children age 0-17.	Various state data systems collected for system of care counties
	CE 4: Number of bed days in acute psychiatric hospitals for children age 0-17	Various state data systems collected for system of care counties

DOMAIN: OUTCOMES

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Living Situation		
Concern: Children and adolescents who are seriously emotionally disturbed should remain in their homes whenever possible or should be placed in the least restrictive, most appropriate, natural environment as close to home as possible.	**Outcome 1:** Number of days in each placement during the year.	
	Outcome 2: Level of restrictiveness of each placement.	

DRAFT

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Concern: Children and adolescents who are seriously emotionally disturbed should be afforded maximum stability in their living situations, moving during the year as few times as possible consistent with their treatment needs.	**Outcome 3:** Number of places a child has lived during the year.	
	Outcome 4: Subjective satisfaction of children and families with the children's living situation.[7]	
Psychological Health		
Concern: The level of psychological distress from symptoms experienced by a child or adolescent is minimized.	**Outcome 5:** Percentage of children and adolescents who experience a reduction in psychological distress.	
Concern: The level of distress experienced by a family with children or adolescents with serious emotional disturbances is minimized.	**Outcome 6:** Percentage of children and adolescents whose families experience improved functioning or a reduction in family distress.	
Physical Health and Safety		
Concern: Children and adolescents who are seriously emotionally disturbed should have an individualized plan of coordinated care that anticipates and addresses their unique and multiple needs, including physical health and need for medication.	**Outcome 7:** Percentage of children and adolescents with serious emotional disturbances whose health is affected by collateral physical health problems who are receiving comprehensive services coordinated between their mental health care and physical health care provider.	

[7] The idea is to develop subjective satisfaction scales modeled after those on the CA-QOL and QL-SF.

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
	Outcome 8: For children and adolescents on psychiatric medication: ♦ clinician's evaluation of the effectiveness of the medication; ♦ clinician's evaluation of whether they have adequate access to the physician prescribing the medication; ♦ children's evaluation of whether the medication is making them feel better; and ♦ parent's evaluation of whether the medication is improving the children's psychological health.	
Concern: Children and adolescents who are seriously emotionally disturbed should feel safe in all aspects of their lives.	**Outcome 9:** Children and adolescents subjective assessment of whether they feel safe in the following environments:[8] ♦ at home; ♦ in school; and ♦ in the community.	
Social Involvement and Functioning		
Concern: Children and adolescents who are seriously emotionally disturbed should be supported in developing or maintaining nurturing relationships with their families.	**Outcome 10:** Percentage of children and adolescents who have age-appropriate family relationships.	
Concern: Children and adolescents who are seriously emotionally disturbed should be supported in their efforts to maintain a social support system and engage in meaningful activities, including playing, sports, socializing with peers, and other recreational activities.	**Outcome 11:** Percentage of children and adolescents who have age-appropriate social relationships.	
	Outcome 12: Percentage of children and adolescents who have age-appropriate interests and activities.	

[8] The idea is to develop subjective satisfaction scales modeled after those on the CA-QOL and QL-SF.

DRAFT

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
School Involvement and Functioning		
Concern: Children and adolescents who are seriously emotionally disturbed belong in school so that they may benefit from their educational program and are encouraged to achieve their maximum educational potential.	**Outcome 13** Percentage of children and adolescents who are attending school regularly according to: ♦ the child or adolescent; ♦ the parent; and ♦ the clinician.	
	Outcome 14: Percentage of children and adolescents in special education.	
	Outcome 15: Assessment of academic performance according to: ♦ the child or adolescent; ♦ the parent; and ♦ the clinician.	
	Outcome 16: Subjective satisfaction of the child or adolescent with attending school.[9]	
Legal		
Concern: Children and adolescents who are seriously emotionally disturbed should be supported in their efforts to develop and maintain socially responsible behavior, avoid involvement with the juvenile justice system, and remain free of substance abuse and addiction.	**Outcome 17:** Reduction in the percentage of children and adolescents who have a substance abuse problem.	
	Outcome 18: Reduction in the percentage of children and adolescents involved in the juvenile justice system.	
	Outcome 19: Reduction in the recidivism of children and adolescents involved in the juvenile justice system.	
	Outcome 20: Reduction in the percentage of children and adolescents engaging in at-risk behaviors, including vandalism, property destruction, and physical assault.	

[9] The idea is to develop subjective satisfaction scales modeled after those on the CA-QOL and QL-SF.

INDICATORS AND MEASURES FOR SYSTEM OVERSIGHT FOR ADULTS WITH SERIOUS MENTAL ILLNESSES

CONTEXT, RISK ADJUSTMENT, OR CASE MIX VARIABLES[10]

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Differences among counties		
Concern: Differences among counties in resources, socioeconomic conditions, demographics, and client characteristics must be considered before any comparisons of performance indicator results can be made.	**Risk Adjust. 1:** County poverty rate.	Statistical Abstract
	Risk Adjust. 2: Per capita funding for mental health services for clients age 18-59.	DMH and County Fiscal Systems
	Risk Adjust. 3: Degree of ethnic diversity in county population.	DOF Population Data
	Risk Adjust. 4: Severity of mental illness among client population age 18-59.	Global Assessment of Functioning (GAF) Score

DOMAIN: STRUCTURE

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Staffing		
Concern: Staffing levels, skills, and training are appropriate for meeting the diverse needs of the individuals served, including linguistic and cultural competency.	**Structure 1:** Number of staff per 1,000 clients by personnel classification.	County administration
	Structure 2: Percentage of staff who are bicultural by ethnicity.	County administration Cultural Competency Plans
	Structure 3: Percentage of staff who are bilingual by language.	County administration Cultural Competency Plans

[10] These variables are being introduced for purposes of discussion only.

DRAFT

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Continuity of Care		
Concern: The organization has a single, fixed point of responsibility for clients and provides continuity of care.	**Structure 4:** Under consideration.	None identified
Coordination of Care		
Concern: The organization provides effective linkages to other service systems with which consumers need to interact.	**Structure 5:** Under consideration.	Available only for physical health care from on-site review process
Quality Improvement		
Concern: The organization uses a quality improvement approach to monitor the performance of its system of care.	**Structure 6:** The organization has a quality improvement system in place.	On-site reviews
	Structure 7: Counties are measuring adult performance outcomes and submitting the data to the DMH in a timely fashion.	DMH Performance Outcome Data System
Rights and Complaint Resolution		
Concern: Consumer rights are clearly defined, and procedures for resolution of complaints and grievances are in place and easy to use.	**Structure 8:** Number of formal grievances filed by consumers.	Not collected
	Structure 9: Number of fair hearings filed by consumers.	DMH Ombudsman Office

DOMAIN: ACCESS

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Services Are Reaching the Intended Population		
Concern: Penetration rates demonstrate that services are reaching the intended populations, including culturally and linguistically diverse populations.	**Access 1:** Percentage of county population ages 18-59 who receive mental health services in one year by modes of service as defined by CSIS, gender, ethnicity, and diagnosis.	CSIS

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
	Access 2: Percentage of the county's monthly average Medi-Cal eligibles ages 18-59 who receive mental health services in one year for all aid codes by modes of service, gender, ethnicity, and diagnosis.	Medi-Cal Paid Claims
Quick and Convenient Entry into Services		
Concern: Entry into mental health services is quick, easy, and convenient.	**Access 3:** Percentage of respondents who report that the location of services is convenient. [11]	MHSIP Consumer Survey Q4
	Access 4: Percentage of respondents who report that services are available at times that are convenient.	MHSIP Consumer Survey Q7
	Access 5: Percentage of respondents who report that mental health staff returned their calls within 24 hours.	MHSIP Consumer Survey Q6
Range of Service Options Available		
Concern: Clients can access services that they need.	**Access 6:** Total units of service for each mode of service.	CSIS
	Access 7: Percentage of resources expended on mental health services provided in the field (natural setting, such as home, school, and work).	CSIS
	Access 8: Percentage of respondents who report that services they need are readily available.	MHSIP Consumer Survey Q5 & 8
Cultural and Linguistic Access		
Concern: Clients have access to a primary mental health provider who meets their needs in terms of ethnicity, language, and culture.	**Access 9:** Percentage of respondents who report that staff are sensitive to their ethnicity culture reported by ethnicity and language.	MHSIP Consumer Survey Q13
	Access 10: Percentage of new clients who do not receive a second service within six months of entry in the CSIS reported by ethnicity and language.	CSIS

[11] Positive response to the MHSIP Consumer Survey is operationalized as answering 4 (agree) or 5 (strongly agree).

DRAFT

DOMAIN: APPROPRIATENESS

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Voluntary Participation in Services		
Concern: People using mental health services do so voluntarily and in collaboration with service providers. The use of involuntary mental health intervention is minimized.	**Appro 1:** Percentage of respondents who report actively participate in decisions concerning their treatment.	MHSIP Consumer Survey Q17 & 18
	Appro 2: Percentage of admissions for psychiatric inpatient treatment that are involuntary.	CSIS
Services that Promote Recovery		
Concern: The mental health provider or system offers services that promote the process of recovery.	**Appro 3:** Percentage of Medi-Cal clients for whom medication is prescribed who received prescriptions for: a. atypical antipsychotics b. newer generation anti-depressants	CSIS & Medi-Cal Pharmacy Claims Data
	Appro 4: Percentage of respondents who report receiving services that support recovery.	MHSIP Consumer Survey Q9 & 14
	Appro 5: Percentage of respondents who report being involved in self-help activities.	MHSIP Q29
Services that Maximize Continuity of Care		
Concern: The mental health provider or system maximizes continuity of care.	**Appro 6:** Percentage of people discharged from inpatient services that receive ambulatory services within 7 days.	CSIS
	Appro 7: Percentage of clients in acute psychiatric inpatient care who have a visit from a case manager while in the hospital.	CSIS, but could be difficult to obtain
Minimal Recurrence of Problems		
Concern: People experiencing an episode of acute psychiatric illness receive care that reduced the likelihood of a recurrence within a short period of time.	**Appro 8:** Percentage of inpatient readmissions that occur within 30 days of discharge.	CSIS

DRAFT

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Consumer Involvement in Policy Development, Planning, and Quality Assurance Activities		
Concern: People using mental health services have meaningful involvement in program policy, planning, evaluation, quality assurance, and service delivery.	**Appro 9:** Percentage of full-time equivalent staff positions that are occupied by consumers of mental health services.	Special Studies
	Appro 10: Percentage of mental health consumers on mental health boards and commissions and Quality Improvement Committees.	Special Studies
	Appro 11: Percentage of family members on mental health boards and commissions and Quality Improvement Committees.	Special Studies
Adequate Information to Make Informed Choices		
Concern: Service recipients receive information that enables them to make informed choices about their care.	**Appro 12:** Percentage of respondents who report receiving adequate information to make informed choices.	MHSIP Consumer Survey Q11, 16, & 19

DOMAIN: COST EFFECTIVENESS

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Scarce Resources Expended Efficiently		
Concern: Use of most restrictive and most costly services is minimized to the extent feasible.	**CE 1:** Proportion of total expenditures on services spent on acute inpatient, subacute, and state hospital services.	CSIS & CR/DC

DOMAIN: OUTCOMES

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Living Situation		
Concern: Persons with mental disabilities have the right to choice, privacy, and independence in their living situation.	**Outcome 1:** Percentage of consumers with serious mental illnesses living in their own house or apartment.	CSIS[12]

[12] This measure would be analyzed for clients for whom performance outcome data has been collected.

DRAFT

INDICATORS FOR ADULTS		MEASURES		DATA SOURCE
		Outcome 2:	Percentage of consumers who move to less restrictive settings	CSIS[11]
		Outcome 3:	Percentage of consumers who report being satisfied with their living situation reported by living situation.[13]	QOL 2a, b, c
		Outcome 4:	Mean satisfaction with living situation reported by living situation.	QOL 2a, b, c
Financial Status				
Concern:	Persons with serious mental illnesses should have an adequate income.	**Outcome 5:**	Percentage of consumers who are receiving the benefits to which they are entitled.	County Universal Method of Determining Ability to Pay Systems
		Outcome 6:	Percentage of consumers who report having enough money for each of these necessities: ♦ food ♦ clothing ♦ housing ♦ transportation ♦ social activities	QOL 10
		Outcome 7:	Percentage of consumers who report being satisfied with their finances.	QOL 11a, b, c
		Outcome 8:	Mean satisfaction with finances.	QOL 11a, b, c
Productive Daily Activity				
Concern:	Persons with serious mental disabilities should have the opportunity to engage in meaningful daily activities, e.g., employment, training, education, etc.	**Outcome 9:**	Percentage of clients with serious mental illnesses involved in competitive employment (part-time or full-time).	CSIS[11]
		Outcome 10:	Percentage of clients with serious mental illnesses involved in volunteer activity.	CSIS[11]
		Outcome 11:	Percentage of clients with serious mental illnesses involved in education.	CSIS[11]

[13] For all outcome indicators, satisfaction is operationalized as answering with categories 5 (mostly satisfied), 6 (pleased), or 7 (delighted) on the instrument.

INDICATORS FOR ADULTS		MEASURES		DATA SOURCE
Symptoms				
Concern:	The level of psychological distress from symptoms is minimized.	**Outcome 12:**	Percentage of consumers experiencing a decreased level of psychological distress.	GAF score, & MHSIP Q26
		Outcome 13:	Suicide rate among persons with serious mental illnesses.	CSIS & Vital Statistics, but could be difficult to obtain
Psychological Functioning				
Concern:	Service recipients experience increased independent functioning.	**Outcome 14:**	Percentage of consumers who report increased functioning.	MHSIP Q20-25
Physical Health				
Concern:	Mental health services recipients should have good health and equal access (relative to the general population) to effective general health care.	**Outcome 15:**	Percentage of Medi-Cal clients who receive mental health services during the year who also received physical health care services through Medi-Cal.	CSIS or Medi-Cal Paid Claims & DHS Medi-Cal Data
		Outcome 16:	Mean score on quality of health reported by consumers.	QOL 15
		Outcome 17:	Percentage of consumers who report being satisfied with their health.	QOL 16a, b, c
		Outcome 18:	Mean satisfaction with health.	QOL 16a, b, c
Substance Abuse				
Concern:	Clients experience minimal impairment from use of substances.	**Outcome 19:**	Rate of all adults receiving services who are identified with substance abuse problems.[14]	CSIS[15]
Avoiding Legal Problems				
Concern:	Clients should be assisted in their efforts to maintain socially responsible behavior.	**Outcome 20:**	Percentage of consumers who report being arrested in the last month.	QOL 13

[14] As long as under-reporting of substance abuse is a problem, this rate should be compared with the known prevalence rate of dual diagnosis among persons with serious mental illnesses.

[15] This measure would be analyzed for clients for whom performance outcome data has been collected.

DRAFT

INDICATORS FOR ADULTS		MEASURES		DATA SOURCE
Personal Safety				
Concern:	Persons with serious mental disabilities have a right to personal safety and freedom from exploitation.	**Outcome 21:**	Percentage of consumers who report being a victim of a violent crime in the past month.	QOL 12a
		Outcome 22:	Percentage of consumers who report being a victim of a non-violent crime in the past month.	QOL 12b
		Outcome 23:	Percentage of consumers who report being satisfied with their personal safety.	QOL 14a, b, c
		Outcome 24:	Mean satisfaction with personal safety.	QOL 14a, b, c
Social Support Networks				
Concern:	Service recipients experience increased natural supports and social integration.	**Outcome 25:**	Percentage of consumers who experience increased activities with family.	QOL 4, 5
		Outcome 26:	Percentage of consumers who report being satisfied with their family contact.	QOL 6a, b
		Outcome 27:	Mean satisfaction with family contact.	QOL 6a, b
		Outcome 28:	Percentage of consumers who experience increased activities with friends, neighbors, or social groups.	QOL 7a, b, c, d
		Outcome 29:	Percentage of consumers who report being satisfied with their social relations.	QOL 8a, b, c, d
		Outcome 30:	Mean satisfaction with social relations.	QOL 8a, b, c, d

INDICATORS FOR SYSTEM OVERSIGHT FOR OLDER ADULTS WITH SERIOUS MENTAL ILLNESSES[16]

CONTEXT, RISK ADJUSTMENT, OR CASE MIX VARIABLES[17]

INDICATORS FOR OLDER ADULTS	MEASURES	DATA SOURCE
Differences among counties		
Concern: Differences among counties in resources, socioeconomic conditions, demographics, and client characteristics must be considered before any comparisons of performance indicator results can be made.	**Risk Adjust. 1:** County poverty rate.	Statistical Abstract
	Risk Adjust. 2: Per capita funding for mental health services for ages 60 and older.	DMH and County Fiscal Systems
	Risk Adjust. 3: Degree of ethnic diversity in county population.	DOF Population Data
	Risk Adjust. 4: Severity of mental illness among client population for ages. 60 and older**.**	

DOMAIN: STRUCTURE

INDICATORS FOR OLDER ADULTS	MEASURES	DATA SOURCE
Staffing		
Concern: Staffing levels and training are appropriate for delivery of the array of services and provide for meeting the diverse needs of the individuals served, including linguistic and cultural competency	**Structure 1:** Number of staff per 1,000 clients by personnel classification.	County administration
	Structure 2: Percentage of staff who are bicultural by ethnicity.	County administration Cultural Competency Plans

[16] The intention of the CMHPC is to recommend measures for which data are available. Because the set of instruments for collecting data in the older adult system of care is under development, data sources have not been specified for some measures. Modifications will have to be made to these proposed measures once instruments are selected.

[17] These variables are being introduced for purposes of discussion only.

DRAFT

INDICATORS FOR OLDER ADULTS	MEASURES	DATA SOURCE
	Structure 3: Percentage of staff who are bilingual by language.	County administration Cultural Competency Plans
Continuity of Care		
Concern: The organization has a single, fixed point of responsibility for consumers and provides continuity of care.	**Structure 4:** Under consideration.	None identified
Coordination of Care		
Concern: The organization provides effective linkages to other service systems with which consumers need to interact.	**Structure 5:** Under consideration.	Available only for physical health care from on-site review process
Quality Improvement		
Concern: The organization uses a quality improvement approach to monitoring the performance of its system of care.	**Structure 6:** The organization has a quality improvement system in place.	On-site reviews
	Structure 7: Counties are measuring older adult performance outcomes and submitting the data to the DMH in a timely fashion.	DMH Performance Outcome Data System
Rights and Complaint Resolution		
Concern: Consumer rights are clearly defined and procedures for resolution of complaints and grievances are in place and easy to use.	**Structure 8:** Number of formal grievances filed by consumers.	Not collected
	Structure 9: Number of fair hearings filed by consumers.	DMH Ombudsman Office

DRAFT

DOMAIN: ACCESS

INDICATORS FOR OLDER ADULTS	MEASURES		DATA SOURCE
Services Are Reaching the Intended Population			
Concern: Penetration rates demonstrate that services are reaching the intended populations, including culturally and linguistically diverse populations.	**Access 1:**	Percentage of county population ages 60 and older who receive mental health services in one year by modes of service as defined by CSIS, gender, ethnicity, and diagnosis.	CSIS
	Access 2:	Percentage of the county's monthly average Medi-Cal eligibles ages 60 and older who receive mental health services in one year for all aid codes by modes of service, gender, ethnicity, and diagnosis.	Medi-Cal Paid Claims
Quick and Convenient Entry into Services			
Concern: Entry into mental health services is quick, easy, and convenient.	**Access 3:**	Percentage of respondents for whom the location of services is convenient.	MHSIP Consumer Survey Q4
	Access 4:	Percentage of respondents for whom services are available at times that are convenient.	MHSIP Consumer Survey Q7
	Access 5:	Percentage of respondents who report that mental health staff returned their calls within 24 hours.	MHSIP Consumer Survey Q6
Range of Service Options			
Concern: Clients can access services that they need	**Access 6:**	Total units of service for each mode of service.	CSIS
	Access 7:	Percentage of resources expended on mental health services provided in the field (natural setting, such as home, school, and work).	CSIS
	Access 8:	Percentage of respondents who report that services they need are readily available.	MHSIP Consumer Survey Q5 & 8
Cultural and Linguistic Access			
Concern: Clients have access to a primary mental health provider who meets their needs in terms of ethnicity, language, and culture.	**Access 9:**	Percentage of respondents who report that staff are sensitive to their ethnicity and culture reported by ethnicity and language.	MHSIP Consumer Survey Q13
	Access 10:	Percentage of new clients who do not receive a second service within six months of entry in the CSIS reported by ethnicity and language.	CSIS

DRAFT

DOMAIN: APPROPRIATENESS

INDICATORS FOR OLDER ADULTS	MEASURES	DATA SOURCE
Voluntary Participation in Services		
Concern: People using mental health services do so voluntarily and in collaboration with service providers. The use of involuntary mental health intervention is minimized.	**Appro 1:** Percentage of respondents who report actively participating in decisions concerning their treatment.	MHSIP Consumer Survey Q17 & 18
	Appro 2: Percentage of admissions for psychiatric inpatient treatment that are involuntary.	CSIS
Services that Promote Recovery		
Concern: The mental health provider or system offers services that promote the process of recovery.	**Appro 3:** Percentage of Medi-Cal clients for whom medication is prescribed who received prescriptions for: a. atypical antipsychotics b. newer generation anti-depressants	CSIS & Medi-Cal Pharmacy Claims Data
	Appro 4: Percentage of respondents who report receiving services that support recovery.	MHSIP Consumer Survey Q9 & 14
	Appro 5: Percentage of respondents who report being involved in self-help activities.	MHSIP Q29
Services that Maximize Continuity of Care		
Concern: The mental health provider or system maximizes continuity of care.	**Appro 6:** Percentage of people discharged from inpatient services that receive ambulatory services within 7 days.	CSIS
	Appro 7: Percentage of clients in acute psychiatric inpatient care who have a visit from a case manager while in the hospital.	CSIS, but could be difficult to obtain
Minimal Recurrence of Problems		
Concern: People experiencing an episode of acute psychiatric illness receive care that reduced the likelihood of a recurrence within a short period of time.	**Appro 8:** Percentage of inpatient readmissions that occur within 30 days of discharge.	CSIS

DRAFT

INDICATORS FOR OLDER ADULTS		MEASURES		DATA SOURCE
Consumer Involvement in Policy Development, Planning, and Quality Assurance Activities				
Concern:	People using mental health services have meaningful involvement in program policy, planning, evaluation, quality assurance, and service delivery.	**Appro 9:**	Percentage of full-time equivalent staff positions that are occupied by consumers of mental health services age 60 and over.	Special Studies
		Appro 10:	Percentage of mental health consumers age 60 and over on mental health boards and commissions and Quality Improvement Committees.	Special Studies
		Appro 11:	Percentage of family members on mental health boards and commissions and Quality Improvement Committees.	Special Studies
Adequate Information to Make Informed Choices				
Concern:	Service recipients receive information that enables them to make informed choices about their care.	**Appro 12:**	Percentage of respondents who receive adequate information to make informed choices.	MHSIP Consumer Survey Q11, 16, & 19

DOMAIN: COST EFFECTIVENESS

INDICATORS FOR OLDER ADULTS		MEASURES		DATA SOURCE
Scarce Resources Expended Efficiently				
Concern:	Use of most restrictive and most costly services is minimized to the extent feasible.	**CE 1:**	Proportion of total expenditures on services spent on acute inpatient, subacute, and state hospital services.	CSIS & CR/DC

DOMAIN: OUTCOMES

INDICATORS FOR OLDER ADULTS		MEASURES		DATA SOURCE
Physical Health				
Concern:	Mental health services recipients should have equal access (relative to the general population) to effective general health care.	**Outcome 1:**	Percent of Medi-Cal clients age 60 and older who receive mental health services during the year that also received physical health care services through Medi-Cal.	CSIS & DHS Medi-Cal Data

DRAFT

INDICATORS FOR OLDER ADULTS		MEASURES		DATA SOURCE
		Outcome 2:	Mean score on quality of health reported by consumers.	
		Outcome 3:	Percentage of consumers who report being satisfied with their health.	
		Outcome 4:	Mean satisfaction with health.	
Symptoms				
Concern:	The level of psychological distress from symptoms is minimized.	**Outcome 5:**	Percentage of consumers who experience a decreased level of psychological distress.	GAF score, & MHSIP Q26
		Outcome 6:	Suicide rate among persons with serious mental illnesses.	CSIS & Vital Statistics, but could be difficult to obtain
Psychological Functioning				
Concern:	Service recipients experience increased independent functioning.	**Outcome 7:**	Percentage of consumers who report increased functioning.	MHSIP Q20-25
Substance Abuse				
Concern:	Clients experience minimal impairment from use of substances.	**Outcome 8:**	Rate of all adults receiving services who are identified with substance abuse problems.[18]	CSIS[19]
Productive Daily Activity				
Concern:	Persons with serious mental disabilities should have the opportunity to engage in meaningful daily activities, e.g., employment, training, education, etc.	**Outcome 9:**	Proportion of older adults with serious mental illnesses involved in competitive employment.	CSIS[18]
		Outcome 10:	Proportion of older adults with serious mental illnesses involved in volunteer activity.	CSIS[18]

[18] As long as under-reporting of substance abuse is a problem, this rate should be compared with the known prevalence rate of dual diagnosis among persons with serious mental illnesses.

[19] This data would be analyzed for clients for whom performance outcome data has been collected.

INDICATORS FOR OLDER ADULTS		MEASURES		DATA SOURCE
Capacity for Independent Community Living				
Concern:	Clients function in community settings with optimal independence from formal service systems.	**Outcome 11:**	Percentage of older adults with serious mental illnesses living in their own home or apartment**.**	CSIS[20]
Concern:	Service recipients experience increased independent functioning.	**Outcome 12:**	Percentage of consumers who experience increased functioning.	
Social Support Network				
Concern:	Service recipients experience increased natural supports and social integration.	**Outcome 13:**	Percentage of consumers who experience increased activities with family, friends, neighbors, or social groups.	

[20] This data would be analyzed for clients for whom performance outcome data has been collected.

CHAPTER 9

IMPLEMENTATION

WHY SHOULD THE *CALIFORNIA MENTAL HEALTH MASTER PLAN* BE UPDATED?

Chapter 1313, Statutes of 1989 (AB 904, Farr) mandated the development of the *California Mental Health Master Plan*. This plan was submitted to the Legislature and the mental health constituency in October 1991. The *Master Plan* contained concepts and recommendations that were lacking in much of the mental health system at the time, including defined priority populations for children and youth, adults, and older adults; an array of services for these populations; recommendations for resource allocation; recommendations for governance and responsibilities of the State and counties; and recommendations for evaluating the effectiveness of service delivery.

The preparation of the *Master Plan* coincided with the realignment legislation (Chapter 89, Statutes of 1991). The system reform elements of realignment, such as client-driven service planning and target populations, were drawn from the *Master Plan*. With the realignment of funding, counties could now rely on a constant funding base from which to plan for the provision of mental health services. This stability has facilitated the implementation of many of the recommendations in the original *Master Plan*.

The California Mental health Planning Council (CMHPC) made updating the *Master Plan* one of its priorities. Although the *Master Plan* had been a visionary blueprint for the public mental health system in the early 1990's, the system was changing rapidly, and many of the original recommendations had been implemented or had become obsolete. The CMHPC believes that the updated *Master Plan* will provide a fresh vision for the mental health system. It provides new recommendations to achieve a more effective mental health system. The CMHPC hopes that the *Master Plan* will continue to be a catalyst for system change that will eventually result in systems of care in all counties for all people who need public mental health services.

Increased Funding Creates a Positive Environment for Implementation

California now is enjoying prosperous times. After years of underfunding since deinstitutionalization in the 1960s, many policymakers are acknowledging the extreme need of the mental health system. In fact, the Honorable John Burton, President Pro Tempore of the Senate, requested no less than $300 million in the state budget for Fiscal Year 2000-01 to fund expansion of the State's mental health services. Policymakers have begun to understand what has happened by neglecting the needs of persons with mental illness for so long: increased burdens on individuals, families, communities, and the criminal justice system.

The Budget for Fiscal Year 2000-01 has provided a $160 million augmentation to the mental health budget. This augmentation represents the biggest single-year increase in mental health spending in California's history. Never before has the Legislature given the mental health system such a high priority for funding. With all of this support, the possibility of additional mental health funding in future years looks promising. In addition, this augmentation and the positive climate for future funding will facilitate implementation of the recommendations contained in this updated *Master Plan*.

Human Resources

One of the issues that has not been discussed in this update is the human resources crisis in the mental health field in California. The CMHPC is already acting on this issue in a separate project. Without the availability of an adequate, well-trained, and diverse workforce, many of the recommendations cannot be implemented. Immediate attention to this problem was necessary so the CMHPC has made it a top priority and has already started a multi-year effort to address the problem.

CHART OF RECOMMENDATIONS

The CMHPC considers the recommendations in the *Master Plan* to be our action plan for advocacy and a blueprint for future actions. The following chart contains a diverse set of recommendations that have been taken from all of the chapters. They are organized in the following manner:

- Location. Each recommendation is listed by the chapter from which it originates.
- Recommendation. Each recommendation is derived from discussion about a particular issue in the chapter from which it originates.

DRAFT

- Responsible party. This category includes a diverse set of organizations, agencies, and advocacy groups at the state and local levels. The CMHPC will be communicating with the entities that are designated to complete each recommendation.
- Type of activity. The recommendations may require legislative or regulatory action; oversight; training programs at all levels of government; interagency cooperation and collaboration; or data collection for further development of issues.
- Timeframe. The timeframes include "short-term," "long-term," and "ongoing." They were chosen for each recommendation to estimate the time that will be necessary for implementation.

The CMHPC will take responsibility for monitoring the implementation of all the recommendations. In addition, the CMHPC is directly responsible for many of the recommendations. The implementation of many of these recommendations will depend on several variables, including funding and resources.

[NOTE: THE IMPLEMENTATION CHART, WHICH IS A COMPENDIUM OF ALL RECOMMENDATIONS IN THE MASTER PLAN, WILL BE ADDED AFTER IT IS FINALIZED.]

DRAFT

DRAFT

REFERENCES

Allness, D., Knoedler, W. (1998). *The PACT model of community-based treatment for persons with severe and persistent mental illnesses: A manual for PACT start-up*.

Anthony, W. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*.

Bazemore, G., & Umbreit, M. (1997). *Balanced and restorative justice for juveniles: A framework for juvenile justice in the 21st century* . Baltimore, Md.: Office of Juvenile Justice and Delinquency Prevention.

Boaz, T., & Dow, M. G. (1999). Risk Adjusting the Florida Outcomes: Relationships among independent variables and dependent variables. Paper presented at the Mental Health Outcomes Risk-Adjustment: A National Research Development Conference.

California Department of Mental Health. (1997a). *The California State Department of Mental Health* . Sacramento.

California Department of Mental Health. (1997b). *Dual diagnosis program*.

California Department of Mental Health. (1998a). DMH Information Notice No. 98-20.

California Department of Mental Health. (1998b). *Mental health Medi-Cal managed care oversight* . Sacramento.

California Department of Mental Health. (1998c). *Mental health Medi-Cal managed care oversight discussion paper* . Sacramento.

California Department of Mental Health. (1999). *Substance Abuse and Mental Health Administration Community Mental Health Services Block Grant Application for Federal Fiscal Year 2000* . Sacramento.

California Infant Mental Health Work Group. (1996). *The California infant mental health work group report* . Sacramento.

California Institute for Mental Health. (1999). *Gender matters: Building a system of services and treatment for women in California* . Sacramento, CA.

California Medical Association. Resolution 710-98: Primary care physicians and mental illness screening .

California Mental Health Directors Association. (2000). *Adult System of Care Framework* .

Center for Mental Health Services. (1999). Estimation methodology for adults with serious mental illness (SMI). *Federal Register, 64*(121), 33890-33897.

Cohen, G. (1980). Prospects for mental health and aging. In J. E. Buren, Sloan, L. B. (Ed.), *Handbook of mental health and aging* (pp. 971-994). Englewood Cliffs.

Cross, T. L., Bazron, B. J., Dennis, K. W., & Isaacs, M. R. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed* . Washington, D. C.: National Technical Assistance Center for Children's Mental Health.

Egnew, R., Geary, C. (1996). Coordinating physical and behavioral healthcare services for Medicaid populations: Issues and implications in integrated and carve-out systems. *Behavioral Healthcare Tomorrow*, 67-71.

Evens, C. C., & Vander Stoep, A. (1997). Risk factors for juvenile justice system referral among children in a public mental health system. *The Journal of Mental Health Administration, 24*(4), 443-455.

Friedman, R. M., Katz-Leavy, J. W., Manderscheid, R. W., & Sondheimer, D. L. (1996). Prevalence of serious emotional disturbance in children and adolescents. In R. W. Manderscheid, M.A. Sonnenschein (Eds.), *Mental Health, United States, 1996* . Washington D.C.: U.S. Government Printing Office.

Goodwin, S. N., & Selix, R. (1998). *The development of California's publicly funded mental health system* . Sacramento, CA: California Institute for Mental Health.

DRAFT

Groshart, J. (1997). *Providing services to students with psychological disabilities* . Sacramento: California Association of Public Education Directors.

Hendryx, M. (1999). *Mental health outcomes risk-adjustment theory: Characteristics of variables and models*. Paper presented at the Mental Health Outcomes Risk-Adjustment: A National Research Development Conference, Spokane, WA.

Holshuh, J. (1992). *Social functioning and social networks among the chronic mentally ill.* , University of California, Berkeley.

Illig, D. *Birth to kindergarten: The importance of the early years* . Sacramento: California Research Bureau, California State Library.

Institute of Medicine. (1991). *The computer-based patient record: An essential technology for health care*. Washington D.C.: National Academy Press.

Izumi, L., Schiller, M., Hayward, S. (1996). *Corrections, criminal justice, and the mentally ill: Some observations about costs in California* .

Kamis-Gould, E., Hadley, T. (1996). *Toolkit: A model of indicators & a report card for assessment of mental health plans' and systems' performance.* Boston: Evaluation Center @ HSRI.

Kaplan, A., Sadock, B., Grebb, J. (1998). *Synopsis of psychiatry*. (7th ed.): Lippincot, Williams & Wilkins.

Kessler, R., Berlund, P., Zhao, S., Lear, P., et al. (1996). The 12-month prevalence and correlates of serious mental illness (SMI). In R. W. Manderscheid, Sonnenschein, M.A. (Ed.), *Mental Health, United States, 1996* (pp. 59-70). Washington D.C.: U.S. Government Printing Office.

Kessler, R. W., Berglund, P.A., Walters, E. E, Leaf, P. J., et al. (1997). *Estimation of the 12-month prevalence of serious mental illness (SMI)* (Working Paper #8): Center for Mental Health Services.

Knitzer, J. (2000). Early childhood mental health services through a policy and systems development perspective. In S. J. Meisels, Shonkoff, J.P. (Ed.), *Handbook of early childhood intervention* (Second ed.,). New York: Cambridge University Press.

Koran, L. (1985). *Physical illness in a sampling of California psychiatric patients.* Paper presented at the Academy of Psychosomatic Medicine 32nd Annual Meeting.

Long, V. T. (1988). : National Resource Center on Homelessness and Mental Illness.

Los Angeles County Task Force on the Incarcerated Mentally Ill. (1993). *Final report to the Los Angeles County Board of Supervisors* .

Mead, S. M., & Copeland, M. E. (2000). What recovery means to us: Consumers' perspectives. *Community Mental Health Journal, 36*(3), 315-328.

Meinhardt, K., Spitznagel, E., Jerrell, J. (1990). *California mental health needs met by local and state hospital services* . San Jose: Santa Clara County Research Center.

Monahan, J., Link, B., Stueve, A., Kikuzawa, S. The public's view of the competence, dangerousness, and need for legal coercion of persons with mental health problems. *American Journal of Public Health, 89*(9), 1339-1345.

Monahan, J. (1998). *The MacArthur violence risk assessment study* .

National Alliance for the Mentally Ill. (2000). *Employment, work, and income supports for people with brain disorders* [2000, 2/9].

National Association of State Mental Health Program Directors. (2000). NASMHPD position statement on employment and rehabilitation.

National Center for State Courts. (1998). *Report on trends in the state courts, 1996-1997* . Williamsburg, VA: National Center for State Courts.

DRAFT

National Council on Disability. (1997). *Removing barriers to work: Action proposals for the 105th congress and beyond* .

National Institute of Mental Health. (1987). *Toward a model plan for a comprehensive community-based mental health system* .

National Mental Health Association. (1999). *Prevalence of mental disorders among children in the juvenile justice system* . Alexandria, VA: National Mental Health Association.

Pacula, R. L., & Sturm, R. (2000). Mental health parity legislation: Much ado about nothing? *Health Services Research, 35*, 263-275.

Parten, D., & Tracy, G. (in press). California community colleges experiences: Evaluation of the community college system and exemplary programs for students with psychological disabilities. In IAPSRS and Boston University (Eds.), *Supported education and psychiatric rehabilitation*.

Presson, N. (2000). Personal Communication.

Salzer, M. S., Nixon, C. T., Schut, L. J., Karver, M. S., Bickman, L. (1997). Validating quality indicators. *Evaluation Review, 21*(3), 292-309.

Sofaer, S. (1995). *Performance indicators: A commentary from the perspective of an expanded view of health* : The Center for the Advancement of Health and the Western Consortium for Public Health.

State of California. TITLE IX, Chapter 11, Medi-Cal Specialty Mental Health Services, *California Code of Regulations* . Sacramento.

Stroul, B. (1989). Community support systems for persons with long-term mental illness: A conceptual framework. *Psychosocial Rehabilitation Journal*.

Substance Abuse and Mental Health Administration. (1999). *The relationship between mental health and substance abuse among adolescents* . Rockville, MD: Substance Abuse and Mental Health Administration.

Task Force on a Consumer-Oriented Mental Health Report Card. (1996). *The MHSIP consumer-oriented report card* .

Tootelian, D. H., & Gaedeke, R. M. (1999). *The impact of housing availability, accessibility, and affordability on people with disabilities* . Sacramento: State Independent Living Council.

Turner, J., Shifren, I. Community support systems: How comprehensive. *New Directions for Mental Health, 2*, 1-23.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the surgeon general* . Rockville, MD: Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Van Ness, D., & Brookes, D, ed. (2000). *Tutorial: Introduction to restorative justice*, [Web site]. Restorative Justice Online [2000, July 18].